Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 27, 2018	2018_751649_0019	014283-17, 014840-17, 016910-17, 018641-17, 024596-17, 029721-17, 027911-18	Critical Incident System

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

St. George Care Community
225 St. George Street TORONTO ON M5R 2M2

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JULIEANN HING (649), ARIEL JONES (566)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 10, 11, 12, 15, 16, 17, 18, and 19, 2018.

The following intakes were inspected:
Log #014283-17/ Critical Incident System (CIS) #2594-000045-17 and log #014840-17/ CIS #2594-000047-17 related to falls prevention and management
Log #016910-17/CIS #2594-000051-17, log #024596-17/CIS #2594-000058-17, log #029721-17/CIS #2594-000069-17, log #018641-17/CIS #2594-000053-17, and log #027911-18/CIS #0594-000059-18 related to allegation of abuse
Log #029721-17/CIS #2594-000069-17 related to elopement

This inspection was conducted concurrently with complaint inspection report #2018_514566_0010 for log #023099-18 related to plan of care and availability of supplies.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), assistant Director of Care (ADOC), evening nurse manager, registered nurses (RNs), physiotherapist (PT), registered practical nurses (RPNs), and personal support workers (PSWs).

During the course of the inspection the inspector(s) observed delivery of resident care and services, observed staff to resident interactions including resident to resident interactions, reviewed resident's health records, reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
2 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #005 and #006 were protected from sexual abuse by resident #004.

Under O. Reg. 79/10, s.5 for the purpose of the definition of "sexual abuse" in subsection 2 of the Act, "sexual abuse" means any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A CIS was submitted to the Ministry of Health and Long-Term Care (MOHLTC) alleging that resident #004 was observed by PSW #105 touching resident #005 in an identified area of the home. According to the CIS resident #004 initially denied touching resident #005 but later acknowledged in an interview with the DOC that they had touched resident #005 without their consent. The police were notified but no charges were laid.

A review of the resident #004's most recent Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment indicated that the resident was cognitively intact.

According to resident #005's most recent RAI-MDS assessment they had moderate impairment. The resident was not interviewable during this inspection.

During an interview with PSW #105, they told the inspector that they had observed resident #004 moving around in an identified area of the home using their mobility aid where resident #005 was sitting. According to the PSW resident #004 had approached resident #005 and started grabbing at an identified part of their body. Based on the definition of sexual abuse, the DOC and PSW acknowledged that resident #005 had not been protected from sexual abuse.

Further record review indicated that the above mentioned incident involving resident #004 inappropriately touching another resident was not the first incident. According to resident #004's progress notes they had been observed by a staff member touching another resident in an identified area of the home prior to the above mentioned CIS. Resident #004 denied the allegation and the police were notified. As a result of the above incident resident #004's care plan was updated to reflect the inappropriate sexual behavior. The care plan stated that the resident required monitoring when off the unit by staff.

With reference to the first CIS there were no updates made to the resident #004's care plan after the incident of resident #004 inappropriately touching resident #005 in an identified area of the home. According to the physician's order and medication administration record (MAR) resident #004 was started on the first identified medication which was later discontinued and then started on a second medication which they are currently taking.

On an identified date resident #004 was assessed by an identified Outreach Team with recommendations made for the resident to be further assessed after the second incident of inappropriately touching resident #006. On another identified date the resident was further assessed and recommendations made for resident #004 to continue with the first medication and should the inappropriate behaviour continue, to switch to the third medication. This recommendation was not implemented by the home and instead the resident was put on the second medication after the second incident.

A second CIS was submitted to MOHLTC on another date alleging that resident #004 had been observed by resident #012 touching resident #006 inappropriately in an area of the home. According to the CIS resident #006 had consented to resident #004 touching them, however resident #006 had moderate impairment and was therefore unable to make their own decisions.

Resident #006 no longer resides in the home and was not available for an interview during this inspection.

Interview with resident #012 told the inspector that they had observed resident #004 touching resident #005 in an identified area of the home.

A review of the home's investigation notes for this CIS indicated that resident #004 acknowledged touching resident #006 in an area of the home in the presence of another

resident and apologized for their actions.

A review of the resident #004's care plan in point click care (PCC) indicated it had been updated after the above incident, to indicate that the resident should be accompanied by staff when in an identified area of the home.

During an interview with PSW #115 who had been working with the resident for the past several years, they told the inspector that they could not recall any monitoring for the resident except that the resident was started on a dementia observation system (DOS) on the day of the interview. The PSW stated they thought they heard the nurse saying that the resident was not allowed in an identified area but was not sure. In response to the question if the resident was allowed to go to an identified area on their own the PSW stated that most of the time the resident went there without any supervision and acknowledged that they were not aware that the resident required supervision in that identified area.

During an interview with RN #116 they told the inspector that resident #004 had inappropriately touched resident #005. RN #116 stated that the inappropriate touching had been observed by PSW #126 while the residents were in an identified area of the home. According to RN #116 resident #004 did "not go extremely out of the way" and had just put their hands on resident #005. RN #116 told the inspector that they had initiated DOS monitoring for resident #004 after the incident and spoken with resident #004 who denied touching resident #005, and stated that resident #004 had this behavior before. RN #116, who was the most responsible person or lead in the home at the time of the incident had not immediately reported this incident to the MOHLTC or followed the home's policy related to this allegation.

The allegation was immediately brought to the DOC's attention by the inspector after the interview with RN #116. The home subsequently submitted a third CIS for the incident that was reported to RN #116 between residents #004 and #005.

Interview with PSW #126 who had witnessed the incident between residents #004 and #005 told the inspector that when resident #004 had entered an identified area of the home resident #005 was already there. They reported that they observed resident #004 touched resident #005 twice. PSW #126 told the inspector that resident #005 was unable to respond and they were unable to intervened.

In a subsequent interview, RN #116 told the inspector they were aware that the incident

between residents #004 and #005 reported by PSW #126 was sexual abuse but it had completely skip their mind and they had not followed the home's policy or process.

During an interview with ADOC #109, they told the inspector that resident #004 will target identified residents when there are no staff visible and acknowledged that resident #005 was not protected from abuse and resident #004's plan of care had not been followed.

During an interview with the DOC, they acknowledged that residents #005 and #006 were not protected from sexual abuse during the above mentioned incidents and stated that they did not think RN #116 had recognized the reported third CIS as sexual abuse as they had not followed the home's process or policy. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A CIS was submitted to the MOHLTC on an identified date alleging that resident #004 had touched resident #005 twice, this incident was witnessed by PSW #126.

A review of the resident #004's care plan in PCC indicated it had been updated that staff to monitor the resident's whereabouts and redirect the resident.

During an interview with PSW #115 who had been working with the resident for the past several years, they told the inspector that they could not recall any monitoring for the resident except that the resident was started on a DOS on the day of the interview. The PSW stated they thought they heard the nurse saying that the resident was not allowed in an identified area but was not sure. In response to the question if the resident was allowed to go to an identified area on their own the PSW stated that most of the time the resident went there without any supervision and acknowledged that they were not aware that the resident required supervision in that identified area.

During interviews, the DOC and ADOC acknowledged that the care set out in the plan of care was not provided to resident #004 as specified in the plan of care. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that any of the following have occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

During an interview with RN #116 they told the inspector that resident #004 had inappropriately touched resident #005. RN #116 stated that the inappropriate touching had been observed by PSW #126 while the residents were in an identified area of the home. According to RN #116 resident #004 did "not go extremely out of the way" and had just put their hands on resident #005. RN #116 told the inspector that they had initiated DOS monitoring for resident #004 after the incident and spoken with resident #004 who denied touching resident #005, and stated that resident #004 had this behavior before. RN #116, who was the most responsible person or lead in the home at the time of the incident had not immediately reported this incident to the MOHLTC or followed the home's policy related to this allegation.

The allegation was immediately brought to the DOC's attention by the inspector after the interview with RN #116. The home subsequently submitted a third CIS for the incident that was reported to RN #116 between residents #004 and #005.

In a subsequent interview, RN #116 told the inspector they were aware that the incident between residents #004 and #005 reported by PSW #126 was sexual abuse but it had completely skip their mind and they had not followed the home's policy or process.

In an interview with the DOC, they told the inspector that RN #116 should have immediately notified the MOHLTC after-hours pager and acknowledged that the sexual abuse had not been immediately reported to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident and that the resident's right to be afforded privacy in treatment and in caring for his or her personal needs was fully respected and promoted, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be afforded privacy in treatment and in caring for his or her personal needs was fully respected and promoted.

The MOHLTC received a CIS related to an allegation of staff to resident abuse involving resident #007 during the provision of care for resident #008. The resident reported that the privacy curtain was not closed while PSW #117 was providing continence care to resident #008 in a shared room. When resident #007 requested the curtain to be closed the PSW refused. The PSW allegedly told resident #008 to "shut up", and grabbed an identified object to threaten them. Resident #007 reported that they hit the PSW with an another identified device in self-defense.

A review of the home's investigation notes into the incident indicated that the accused PSW #117 reported that while they were giving care to resident #007's roommate

(resident #008), resident #007 entered the room and asked them to close the curtain around resident #008. Resident #007 became angry when asked to wait because the PSW's hands were dirty. Resident #007 then reached for an identified object and when it appeared as though resident #007 was going to attempt to injure PSW #117, the PSW grabbed the identified device object from resident #007. Resident #007 then picked up another identified device and hit PSW #117. The PSW called the charge nurse for help. The police became involved and issued a verbal warning to resident #007. The home's investigation concluded that there was a verified residents' rights privacy issue toward resident #008.

Observations of the residents' shared room 101 indicated that their beds located beside each other and a privacy curtain in between. In a drawn position, the privacy curtain was touching the side of resident #008's bed.

In an interview, PSW #117 indicated that they were working one PSW staff short that night shift and that they had finished their assignment and picked up a few more residents on another assignment, including resident #008. They indicated that they had not yet initiated care for resident #008, but that they were checking the resident to determine their care needs. PSW #117 indicated further that the privacy curtain may not have been fully drawn, but before they had time to respond to resident #007's request to close the curtain, resident #007 struck them three times with another identified device. PSW #117 denied all allegations of abuse toward resident #007, and indicated that the privacy curtain around resident #008 had potentially opened when the PSW bent down to check resident #008.

During an interview, RPN #118 indicated that they heard a lot of noise coming from the identified room and when they entered, they saw PSW #117 between the two residents, and resident #007 holding an identified device. RPN #118 indicated further that the privacy curtain was not drawn around resident #008 while PSW #117 had been providing care, and that this had triggered resident #007's behaviour. RPN #118 confirmed that in this instance, resident #008's right to privacy during care was not respected.

The DOC confirmed that all residents have the right to privacy in treatment and in caring for their personal needs, and that the outcome of the home's investigation into the incident concluded that there was a violation of resident #008's right to privacy during care. [s. 3. (1) 8.]

Issued on this 4th day of December, 2018

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIEANN HING (649), ARIEL JONES (566)
Inspection No. / No de l'inspection :	2018_751649_0019
Log No. / No de registre :	014283-17, 014840-17, 016910-17, 018641-17, 024596-17, 029721-17, 027911-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 27, 2018
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	St. George Care Community 225 St. George Street, TORONTO, ON, M5R-2M2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	John Seebach

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 19. (1).

Specifically, the licensee shall ensure that resident #005 and any other residents are protected from sexual abuse by resident #004.

Upon receipt of this compliance order the licensee shall:
1. Implement monitoring to ensure that resident #005 and all other residents are protected from sexual abuse by resident #004.
2. Retrain all registered staff on the unit including RN #116 on the identification of abuse using different scenarios.
3. Ensure that PSWs providing care to resident #004 and any other residents are trained and knowledgeable on the interventions in the residents plan of care.
4. Documentation of what was included in the abuse training, who attended the training, and the dates the training was provided must be kept.

Grounds / Motifs :

1. The licensee has failed to ensure that residents #005 and #006 were protected from sexual abuse by resident #004.

Under O. Reg. 79/10, s.5 for the purpose of the definition of "sexual abuse" in subsection 2 of the Act, "sexual abuse" means any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A CIS was submitted to the Ministry of Health and Long-Term Care (MOHLTC) alleging that resident #004 was observed by PSW #105 touching resident #005 in an identified area of the home. According to the CIS resident #004 initially

denied touching resident #005 but later acknowledged in an interview with the DOC that they had touched resident #005 without their consent. The police were notified but no charges were laid.

A review of the resident #004's most recent Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment indicated that the resident was cognitively intact.

According to resident #005's most recent RAI-MDS assessment they had moderate impairment. The resident was not interviewable during this inspection.

During an interview with PSW #105, they told the inspector that they had observed resident #004 moving around in an identified area of the home using their mobility aid where resident #005 was sitting. According to the PSW resident #004 had approached resident #005 and started grabbing at an identified part of their body. Based on the definition of sexual abuse, the DOC and PSW acknowledged that resident #005 had not been protected from sexual abuse.

Further record review indicated that the above mentioned incident involving resident #004 inappropriately touching another resident was not the first incident. According to resident #004's progress notes they had been observed by a staff member touching another resident in an identified area of the home prior to the above mentioned CIS. Resident #004 denied the allegation and the police were notified. As a result of the above incident resident #004's care plan was updated to reflect the inappropriate sexual behavior. The care plan stated that the resident required monitoring when off the unit by staff.

With reference to the first CIS there were no updates made to the resident #004's care plan after the incident of resident #004 inappropriately touching resident #005 in an identified area of the home. According to the physician's order and medication administration record (MAR) resident #004 was started on the first identified medication which was later discontinued and then started on a second medication which they are currently taking.

On an identified date resident #004 was assessed by an identified Outreach Team with recommendations made for the resident to be further assessed after

the second incident of inappropriately touching resident #006. On another identified date the resident was further assessed and recommendations made for resident #004 to continue with the first medication and should the inappropriate behaviour continue, to switch to the third medication. This recommendation was not implemented by the home and instead the resident was put on the second medication after the second incident.

A second CIS was submitted to MOHLTC on another date alleging that resident #004 had been observed by resident #012 touching resident #006 inappropriately in an area of the home. According to the CIS resident #006 had consented to resident #004 touching them, however resident #006 had moderate impairment and was therefore unable to make their own decisions.

Resident #006 no longer resides in the home and was not available for an interview during this inspection.

Interview with resident #012 told the inspector that they had observed resident #004 touching resident #005 in an identified area of the home.

A review of the home's investigation notes for this CIS indicated that resident #004 acknowledged touching resident #006 in an area of the home in the presence of another resident and apologized for their actions.

A review of the resident #004's care plan in point click care (PCC) indicated it had been updated after the above incident, to indicate that the resident should be accompanied by staff when in an identified area of the home.

During an interview with PSW #115 who had been working with the resident for the past several years, they told the inspector that they could not recall any monitoring for the resident except that the resident was started on a dementia observation system (DOS) on the day of the interview. The PSW stated they thought they heard the nurse saying that the resident was not allowed in an identified area but was not sure. In response to the question if the resident was allowed to go to an identified area on their own the PSW stated that most of the time the resident went there without any supervision and acknowledged that they were not aware that the resident required supervision in that identified area.

During an interview with RN #116 they told the inspector that resident #004 had inappropriately touched resident #005. RN #116 stated that the inappropriate touching had been observed by PSW #126 while the residents were in an identified area of the home. According to RN #116 resident #004 did "not go extremely out of the way" and had just put their hands on resident #005. RN #116 told the inspector that they had initiated DOS monitoring for resident #004 after the incident and spoken with resident #004 who denied touching resident #005, and stated that resident #004 had this behavior before. RN #116, who was the most responsible person or lead in the home at the time of the incident had not immediately reported this incident to the MOHLTC or followed the home's policy related to this allegation.

The allegation was immediately brought to the DOC's attention by the inspector after the interview with RN #116. The home subsequently submitted a third CIS for the incident that was reported to RN #116 between residents #004 and #005.

Interview with PSW #126 who had witnessed the incident between residents #004 and #005 told the inspector that when resident #004 had entered an identified area of the home resident #005 was already there. They reported that they observed resident #004 touched resident #005 twice. PSW #126 told the inspector that resident #005 was unable to respond and they were unable to intervened.

In a subsequent interview, RN #116 told the inspector they were aware that the incident between residents #004 and #005 reported by PSW #126 was sexual abuse but it had completely skip their mind and they had not followed the home's policy or process.

During an interview with ADOC #109, they told the inspector that resident #004 will target identified residents when there are no staff visible and acknowledged that resident #005 was not protected from abuse and resident #004's plan of care had not been followed.

During an interview with the DOC, they acknowledged that residents #005 and #006 were not protected from sexual abuse during the above mentioned incidents and stated that they did not think RN #116 had recognized the reported

third CIS as sexual abuse as they had not followed the home's process or policy.

The severity of this non-compliance was identified as actual harm or risk, the scope was identified as a pattern. Review of the home's compliance history revealed a voluntary plan of correction (VPC) was issued on July 20, 2017, under inspection report #2017_370649_0012 for non-compliance with the LTCHA, 2007 O.Reg. 79/10, s.19. (1). Due to the severity of actual harm or risk and previous non-compliance with a VPC a compliance order is warranted (649)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 01, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 27th day of November, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JulieAnn Hing

Service Area Office /
Bureau régional de services : Toronto Service Area Office