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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 2, 2013	2013_225126_0012	O-000395,000418,000524,603-13	Critical Incident System

Licensee/Titulaire de permis

1663432 ONTARIO LTD.
2212 GLADWIN CRESCENT, UNIT A-9, SUITE 200, OTTAWA, ON, K1B-5N1

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

MANOIR MAROCHEL
949 MONTREAL ROAD, OTTAWA, ON, K1K-0S6

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

LINDA HARKINS (126)

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): June 27, 28, July 2, 4, 5, 8, 23, 24, 30, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Clinical Nurse, several Registered Nursing staff (RN), Several Registered Practical Nurse (RPN), several Personal Support Workers (PSW), several residents, family members, the Psycho Geriatrician Registered Nurse and the Psycho Geriatrician Physician.

During the course of the inspection, the inspector(s) reviewed several Resident Health Care records, reviewed the Critical Incident Report (CRI) System and observed care and services provided tot he residents.

During this inspection several Critical incidents were reviewed.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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	Legendé 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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, C.8 S. 6. (1) (c) in that the home did not provide clear directions to staff and others who provided direct care to Resident #1.

Resident #1's health care record was reviewed for 2010 to 2013. Four incidents of sexual abuse and several potential inappropriate sexual behaviors which could have led to potential sexual abuse were documented in the progress notes for that period. Resident #1 was identified at high risk for potential/actual sexual abuse toward residents.Staff that were providing direct care to Resident #1 were not provided with clear directions as per following evidence:

On July 19, 2013, two Personal Support Workers (PSW) were interviewed by Inspector #126 and they both indicated that the three months staff rotation changed that morning and they were new to Resident #1's unit. During the first morning report,they were not informed about Resident #1's high risks for inappropriate sexual behaviors and how to ensure protection of the other residents. They both indicated that everyone was aware of the behaviors and that Resident #1 was on every 15 minutes monitoring. Another PSW, on the other unit, indicated to Inspector #126 that he/she had several residents that were on monitoring every 15 minutes. He/she could explain how to do the 15 minutes verification but could not indicate the reasons why those residents were on 15 minutes monitoring. Discussion with the Director of Care (DOC), who indicated that the expectation is that the PSW reads the "PSW Report Book" and it is their responsibility to review the list to find out who is on every 15 minutes watch.

During the night shift of a specified day in July 2013, it was observed by Personal Support Worker S #121 potential inappropriate sexual behaviors exhibited by Resident #1 and these behaviors were not immediately reported to the Night Nurse. This information was shared at the end of the night shift in the morning when RN S#100 asked the PSWS if they had anything unusual to report for the night shift. PSW #121 did not have clear direction to report the incident immediately to the Registered Nurse for assessments and interventions to ensure the protection of Resident #7. [s. 6. (1) (c)]

2. The licensee failed to comply with LTCHA 2007, S.O. 2007, c. 8 s. 6. (10) b whereby Resident #2 fell on a specified day in May 2013 and was not reassessed when the care needs changed. Resident condition continued to deteriorate for a few

days, when Resident #2 was found unresponsive one morning in May 2013 and passed away.Resident #2 was on anticoagulant therapy.

In the early morning progress notes of that day, it is documented that Resident #2 was found on the floor and informed staff that he/she hit his/her head on the floor. The night Registered Nurse (RN)S#100 documented that Resident #2 had an hematoma on the right side of his/her forehead.

In the progress note of that day shift, it is documented that Resident #2 complained of headache and that medication for pain was given with no effectiveness documented. There was no documentation on the size or color of the hematoma as previously identified by S#100 earlier that morning. The documentation of the neurological signs monitoring was incomplete as per the requirements of the home's Neurological Assessment Tool.

In two progress notes of the evening shift of that day and the night shift of the next day does not include documentation related the size and color of the hematoma of Resident #2.

In the progress notes of the next day, RPN S#101 documented that the hematoma is bright red under the right eye and that the face of the Resident #2 is swollen.

The early morning of two days post fall, the Physician and the Charge Nurse assessed Resident #2. That same day, RPN S#101 documented that Resident #2 ate poorly at breakfast, complained of pain and bleeding was noted under the two eyes.

In the progress notes of two days post fall, RN S#102 documented that Resident #2 ate poorly at supper and the hematoma and bruising were very pronounced in the face. S #102 documented that Resident #2 had difficulty taking his/her medications at 21:00 and had no verbal complaints.

In the early morning of three days post fall, it is documented in the progress notes, that the Personal Support Worker was unable to wake Resident #2 up .Resident was sent to hospital via ambulance. Resident passed away a few hours later.

According to the above noted entries in the progress notes, Resident #2 condition was deteriorating and the hematoma and bruising increasing in size. No supportive

documentation was identified in the resident health care record related to notifying the physician of the change in Resident #2's condition on the second day post fall. Several Registered Nursing Staff were interviewed by Inspector #126 and they indicated that the physician was in the morning and that they have not notified the physician of the change in condition of Resident #2 because they assumed that the morning assessment was sufficient.

The licensee did not monitor the condition of the resident as per the neurological assessment requirements of the home and did not informed the physician of the increased in size of the hematoma and bruising and the change of the general condition of Resident #2.

The severity of the harm and risk of harm to residents arising from the noncompliance was high. Resident # 2's fall resulted in actual harm and eventual death. The scope of the harm and risk of harm arising from the non-compliance is isolated. The home compliance history consist of one or more non-compliance in last 3 years. [s. 6. (10) (b)]

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. 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 failed to comply with LTCHA, 2007, S. O. 2007, Chapter 8, S. 19, in that the licensee did not protect residents from sexual abuse by Resident #1 between the period of 2011 to 2013. O. Reg 79/10 s. 2(1) (b) defines sexual abuse as: "any non-consensual touching, behavior or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other that a licensee or staff member".

Resident #1's health care record was reviewed for 2010-2013.Four incidents of sexual abuse were documented in the progress notes and several potential inappropriate sexual behaviors were documented during that period.

Resident #1 was admitted to the home several years ago.Resident #1 ambulates with a wheelchair for long distances and uses a walker in the bedroom for transfers from the bed to the chair and to go to the bathroom.

On four occasions, between 2011 and 2013 Resident #1 exhibited sexual behaviors that are documented in the progress notes as follow:

1. It is noted in the progress notes of a specified day in May 2011, that Resident #3 told Registered Nurse (RN) S #103 that Resident #1 had abused him/her that morning. The incident was reported to Management Team that day. The former Director of Care documented in the progress notes that same day, that the Administrator and herself had met with Resident #1 and informed him/her to keep a distance from his/her roommate and if the incident reoccurred, they would be obligated to notify the family, the ministry and the police.

RN S #106, documented in the progress notes, two days after the incident, that upon her/his return from holidays, initiated the monitoring every 15 minutes of the whereabouts of Resident #1 and notified the Psychogeriatric Nurse of Resident #1's behavior. Resident #1 was seen by the Psychogeriatric Physician, who recommended reminding Resident #1 to stay on his/her side of the bedroom and recommended a medication dosage change, which was implemented.

On July 18, 2013, Inspector #126 interviewed RN S #103 regarding the above incident and he/she indicated that he/she remembered the incident well. Resident #1 and Resident #3 were sharing a room at that time. At the start of the shift, pain medication was administered to Resident #3. Later that morning, he/she overheard Resident #3

yelling and walked into the room. Resident #3 reported to him/her, to have been abused by Resident #1.Resident #3 was very upset at that time. Following that incident, S #103 indicated that he/she informed Resident #3's Substitute Decision Maker.

The critical Incident Report (CIR) system was reviewed for that incident and that incident was not reported to the Director.

2. It is noted in the progress notes of a specified date in April 2013, by RN S #111, that Resident #1 was found with his/her hands on the genital area of Resident #6.

On July 24, 2013, Inspector #126 interviewed PSW S #113 regarding the above incident that he/she witnessed. S #113 indicated that he/she was completing the documentation of the "15 minutes monitoring sheet" for Resident #1 when he/she heard Resident #1 humming. At that time, S #113 realized that the humming was coming from the bedroom of Resident #6. Resident #1's hand was observed by PSW S #113 to be under the blanket touching the genital area of Resident #6. He/she indicated that when he/she immediately told Resident #1 to stop and redirected him/her to go to his/her room. RN S #111 came to the room for an assessment.

Several Registered Nursing staff indicated that Resident # 6 is known to have a diagnosis of Dementia and would not be able to consent to sexual touching.

That incident occurred on a specified day in April 2013 and was reported to the Director via CIR two days later. In the progress note,it is documented that S #111 notified the Power of Attorney (POA) of Resident #6 and the police. Resident #1 was visited by two policemen that same day and was told to stay away from Resident #6.

Resident #1 was seen by the Psycho Geriatric Physician related to this incident and they recommended to the home to consider moving Resident #1 closer to the nursing station and to consider getting an alarm that could be activated by movement. A medication dosage increase was suggested and implemented by the home.

3. It is noted in the progress notes of a specified day in June 2013, that Resident #1 was observed on that evening caressing Resident #7 and that Resident #1 was naked while doing this.

On July 24, 2013, Inspector #126 interviewed RPN S #116 via telephone regarding the above incident. He/she indicated he/she observed Resident #1 touching Resident #7 when he/she was doing his/her tour. He/she observed Resident # 7 sitting in the wheelchair with Resident #1 standing beside him/her with the walker in front. Resident #7 was dressed and Resident # 1 had a t-shirt on but was naked from the waist down. Resident #1 was touching Resident #7 in the chest area under his/her shirt. When Resident # 1 saw S #116, he/she walked rapidly with the walker, back to his/hers bed and covered himself/herself.

Staff described Resident #7 as being physically aggressive on occasions. Several Registered Nursing staff indicated that they don't think Resident #7 is capable of giving an informed consent to sexual touching.

This incident was not immediately reported to the Director. The police and the Director were notified approximately 10 days after the incident.

4. It is noted in the evening progress notes of a specified day in June 2013, that Resident #1 got out of bed to go beside his/her roommate (Resident #7) and was touching him/her.

On July 24, 2013, Inspector #126 interviewed PSW S #118 regarding incident of the specified day in June 2013.
S #118 indicated that around 2100 hour, he/she observed Resident #1 beside the bed of Resident #7. He/she asked Resident #1 what he/she was doing there and Resident #1 answered that he/she wanted to have sex with Resident # 7. S #118 redirected Resident #1 to his/her bed.

Resident #7 was observed by S #118 to be resting quietly in bed covered with a blanket. Resident #1 was dressed with short and had no t-shirt on. S #118 indicated that he/she had not seen any inappropriate touching at that time, only Resident #1 making sexual comments. RPN S #114 and PSW S #118 talked with Resident #1 and told him/her that he/she did not have any right to touch Resident #7. No further incident was observed or reported and Resident #1 stayed in bed.

This incident was not reported to the Director or via CIR. An Internal critical incident report was completed that same day S #114. The Power of Attorney (POA) of Resident #7 and the police were not immediately informed of that Incident, they were

notified the following day.

In addition to the above incidents of sexual abuse, Resident #1 was observed on several occasions demonstrating inappropriate behaviors between 2011 and 2013 which could have led to potential sexual abuse.

The Licensee did not protect Resident #3, #6, #7 from sexual abuse by Resident #1. The licensee did not implement effective interventions that would protect residents. The licensee did not immediately report every alleged, suspected or witnessed sexual abuse incidents as per legislative requirements. [s. 19. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 :

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1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, S. 24. (1) in that the licensee did not immediately report sexual abuse of a resident to a resident to the Director.

On a specified day of May 2011, Resident #3 reported to RN S #103 that he/she was abused by Resident #1. The licensee did not informed the Director or complete a critical incident. [s. 24. (1)]

2. On a specify day in April 2013 an incident of abuse occurred and the incident was reported to the Director via CIR two days later, not immediately. [s. 24. (1)]

3. Incidents of abuse that occurred on two different days in June 2013 were not reported immediately to the Director and were reported via one Critical Incident Report several days later. [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 abuse is reported to the Director as per legislative requirements., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 s. 98, in that the licensee did not notify the appropriate police force of an alleged , suspected incident of sexual abuse.

On a specified day of May 2011, Resident #3 reported to RN S #103 that he/she was abuse by Resident #1. This incident of alleged, suspected sexual abuse was not reported to the police force. [s. 98.]

2. An incident of abuse occurred on a specify day in June 2013 and no documentation was found about reporting the incident to the police. [s. 98.]

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 the home report immediately to the appropriate police force any alleged, suspected or witnessed incident of abuse or neglect of a resident., to be implemented voluntarily.

Issued on this 5th day of September, 2013

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

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LINDA HARKINS (126)
Inspection No. / No de l'inspection :	2013_225126_0012
Log No. / Registre no:	O-000395,000418,000524,603-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 2, 2013
Licensee / Titulaire de permis :	1663432 ONTARIO LTD. 2212 GLADWIN CRESCENT, UNIT A-9, SUITE 200, OTTAWA, ON, K1B-5N1
LTC Home / Foyer de SLD :	MANOIR MAROCHEL 949 MONTREAL ROAD, OTTAWA, ON, K1K-0S6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PIERRE BERNIER

To 1663432 ONTARIO LTD., you are hereby required to comply with the following order(s) by the date(s) set out below:

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. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall review and update the plan of care of residents when a fall resulting in significant changes in resident's condition by providing:
-On-going assessment of the resident conditions, specifically related to the use of anti-coagulant, injury, change in appetite and neurological status.
-On-going information on the resident condition to the interdisciplinary team at shift change post fall;
-promptly informing the physician of any changes in resident condition;
-Education to Registered Nursing Staff on how to complete a neurological assessment in accordance with prevailing practices.

Grounds / Motifs :

1. 1. The licensee failed to comply with LTCHA 2007, S.O. 2007, C.8 S. 6. (1) (c) in that the home did not provide clear directions to staff and others who provided direct care to Resident #1.

Resident #1's health care record was reviewed for 2010 to 2013. Four incidents of sexual abuse and several potential inappropriate sexual behaviors which could have led to potential sexual abuse were documented in the progress notes for that period. Resident #1 was identified at high risk for potential/actual sexual abuse toward residents.Staff that were providing direct care to Resident #1 were not provided with clear directions as per following evidence:

On July 19, 2013, two Personal Support Workers (PSW) were interviewed by Inspector #126 and they both indicated that the three months staff rotation changed that morning and they were new to Resident #1's unit. During the first morning report,they were not informed about Resident #1's high risks for inappropriate sexual behaviors and how to ensure protection of the other residents. They both indicated that everyone was aware of the behaviors and that Resident #1 was on every 15 minutes monitoring. Another PSW, on the other unit, indicated to Inspector #126 that he/she had several residents that were on monitoring every 15 minutes. He/she could explain how to do the 15 minutes verification but could not indicate the reasons why those residents were on 15 minutes monitoring. Discussion with the Director of Care (DOC), who indicated that the expectation is that the PSW reads the "PSW Report Book" and it is their responsibility to review the list to find out who is on every 15 minutes watch.

During the night shift of a specified day in July 2013, it was observed by Personal Support Worker S #121 potential inappropriate sexual behaviors exhibited by Resident #1 and these behaviors were not immediately reported to the Night Nurse. This information was shared at the end of the night shift in the morning when RN S#100 asked the PSWS if they had anything unusual to report for the night shift. PSW #121 did not have clear direction to report the incident immediately to the Registered Nurse for assessments and interventions to ensure the protection of Resident #7. [s. 6. (1) (c)]

2. The licensee failed to comply with LTCHA 2007, S.O. 2007, c. 8 s. 6. (10) b whereby Resident #2 fell on a specified day in May 2013 and was not reassessed when the care needs changed. Resident condition continued to deteriorate for a few days, when Resident #2 was found unresponsive one morning in May 2013 and passed away.Resident #2 was on anticoagulant therapy.

In the early morning progress notes of that day, it is documented that Resident #2 was found on the floor and informed staff that he/she hit his/her head on the floor. The night Registered Nurse (RN)S#100 documented that Resident #2 had an hematoma on the right side of his/her forehead.

In the progress note of that day shift, it is documented that Resident #2 complained of headache and that medication for pain was given with no

effectiveness documented. There was no documentation on the size or color of the hematoma as previously identified by S#100 earlier that morning. The documentation of the neurological signs monitoring was incomplete as per the requirements of the home's Neurological Assessment Tool.

In two progress notes of the evening shift of that day and the night shift of the next day does not include documentation related the size and color of the hematoma of Resident #2.

In the progress notes of the next day, RPN S#101 documented that the hematoma is bright red under the right eye and that the face of the Resident #2 is swollen.

The early morning of two days post fall, the Physician and the Charge Nurse assessed Resident #2. That same day, RPN S#101 documented that Resident #2 ate poorly at breakfast, complained of pain and bleeding was noted under the two eyes.

In the progress notes of two days post fall, RN S#102 documented that Resident #2 ate poorly at supper and the hematoma and bruising were very pronounced in the face. S #102 documented that Resident #2 had difficulty taking his/her medications at 21:00 and had no verbal complaints.

In the early morning of three days post fall, it is documented in the progress notes, that the Personal Support Worker was unable to wake Resident #2 up .Resident was sent to hospital via ambulance. Resident passed away a few hours later.

According to the above noted entries in the progress notes, Resident #2 condition was deteriorating and the hematoma and bruising increasing in size. No supportive documentation was identified in the resident health care record related to notifying the physician of the change in Resident #2's condition on the second day post fall. Several Registered Nursing Staff were interviewed by Inspector #126 and they indicated that the physician was in the morning and that they have not notified the physician of the change in condition of Resident #2 because they assumed that the morning assessment was sufficient.

The licensee did not monitor the condition of the resident as per the neurological

assessment requirements of the home and did not informed the physician of the increased in size of the hematoma and bruising and the change of the general condition of Resident #2.

The severity of the harm and risk of harm to residents arising from the noncompliance was high. Resident # 2's fall resulted in actual harm and eventual death. The scope of the harm and risk of harm arising from the non-compliance is isolated. The home compliance history consist of one or more non-compliance in last 3 years. [s. 6. (10) (b)] (126)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 22, 2013

Order # /
Ordre no : 002

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 shall:
1. Ensure Resident #1 is located in an area of the home whereby his whereabouts can be monitored at all times;
2. Identify potential residents that are vulnerable to abuse by Resident #1 and conduct risk analysis to take steps to protect those residents at all times;
3. Develop and implement strategies to manage Resident #1 inappropriate sexual behaviors;
4. Create and implement an effective system for communicating these strategies to all direct care staff and ensure staff understand the rationale behind the use of these strategies and to provide education to all nursing staff in the management of inappropriate sexual behaviors;
5. Review and revise the plan of care of Resident #1 to ensure clear direction is provided to staff and others related to the management of the inappropriate sexual behaviors, such as offering private accommodation,installing an alarm as recommended by the Psycho Geriatrician;
6. Report Incident, inform Police Forces and Substitute Decision Maker when incident of sexual abuse occurs as per legislative requirements;
7. Ensure alleged, suspected or witnessed incident of abuse are thoroughly investigated and appropriate action is taken in response to every such incident of abuse.

Grounds / Motifs :

1. 1. The licensee failed to comply with LTCHA, 2007, S. O. 2007, Chapter 8, S. 19, in that the licensee did not protect residents from sexual abuse by Resident #1 between the period of 2011 to 2013. O. Reg 79/10 s. 2(1) (b) defines sexual abuse as: "any non-consensual touching, behavior or remarks of a sexual nature

or sexual exploitation directed towards a resident by a person other that a licensee or staff member".

Resident #1's health care record was reviewed for 2010-2013.Four incidents of sexual abuse were documented in the progress notes and several potential inappropriate sexual behaviors were documented during that period.

Resident #1 was admitted to the home several years ago.Resident #1 ambulates with a wheelchair for long distances and uses a walker in the bedroom for transfers from the bed to the chair and to go to the bathroom.

On four occasions, between 2011 and 2013 Resident #1 exhibited sexual behaviors that are documented in the progress notes as follow:

1. It is noted in the progress notes of a specified day in May 2011, that Resident #3 told Registered Nurse (RN) S #103 that Resident #1 had abused him/her that morning. The incident was reported to Management Team that day. The former Director of Care documented in the progress notes that same day, that the Administrator and herself had met with Resident #1 and informed him/her to keep a distance from his/her roommate and if the incident reoccurred, they would be obligated to notify the family, the ministry and the police.

RN S #106, documented in the progress notes, two days after the incident, that upon her/his return from holidays, initiated the monitoring every 15 minutes of the whereabouts of Resident #1 and notified the Psychogeriatric Nurse of Resident #1's behavior. Resident #1 was seen by the Psychogeriatric Physician, who recommended reminding Resident #1 to stay on his/her side of the bedroom and recommended a medication dosage change, which was implemented.

On July 18, 2013, Inspector #126 interviewed RN S #103 regarding the above incident and he/she indicated that he/she remembered the incident well. Resident #1 and Resident #3 were sharing a room at that time. At the start of the shift, pain medication was administered to Resident #3. Later that morning, he/she overheard Resident #3 yelling and walked into the room. Resident #3 reported to him/her, to have been abused by Resident #1.Resident #3 was very upset at that time. Following that incident, S #103 indicated that he/she informed Resident #3's Substitute Decision Maker.

The critical Incident Report (CIR) system was reviewed for that incident and that incident was not reported to the Director.

2. It is noted in the progress notes of a specified date in April 2013, by RN S #111, that Resident #1 was found with his/her hands on the genital area of Resident #6.

On July 24, 2013, Inspector #126 interviewed PSW S #113 regarding the above incident that he/she witnessed. S #113 indicated that he/she was completing the documentation of the "15 minutes monitoring sheet" for Resident #1 when he/she heard Resident #1 humming. At that time, S #113 realized that the humming was coming from the bedroom of Resident #6. Resident #1's hand was observed by PSW S #113 to be under the blanket touching the genital area of Resident #6. He/she indicated that when he/she immediately told Resident #1 to stop and redirected him/her to go to his/her room. RN S #111 came to the room for an assessment.

Several Registered Nursing staff indicated that Resident # 6 is known to have a diagnosis of Dementia and would not be able to consent to sexual touching.

That incident occurred on a specified day in April 2013 and was reported to the Director via CIR two days later. In the progress note,it is documented that S #111 notified the Power of Attorney (POA) of Resident #6 and the police. Resident #1 was visited by two policemen that same day and was told to stay away from Resident #6.

Resident #1 was seen by the Psycho Geriatric Physician related to this incident and they recommended to the home to consider moving Resident #1 closer to the nursing station and to consider getting an alarm that could be activated by movement. A medication dosage increase was suggested and implemented by the home.

3. It is noted in the progress notes of a specified day in June 2013, that Resident #1 was observed on that evening caressing Resident #7 and that Resident #1 was naked while doing this.

On July 24, 2013, Inspector #126 interviewed RPN S #116 via telephone

regarding the above incident. He/she indicated he/she observed Resident #1 touching Resident #7 when he/she was doing his/her tour. He/she observed Resident # 7 sitting in the wheelchair with Resident #1 standing beside him/her with the walker in front. Resident #7 was dressed and Resident # 1 had a t-shirt on but was naked from the waist down. Resident #1 was touching Resident #7 in the chest area under his/her shirt. When Resident # 1 saw S #116, he/she walked rapidly with the walker, back to his/hers bed and covered himself/herself.

Staff described Resident #7 as being physically aggressive on occasions. Several Registered Nursing staff indicated that they don't think Resident #7 is capable of giving an informed consent to sexual touching.

This incident was not immediately reported to the Director. The police and the Director were notified approximately 10 days after the incident.

4. It is noted in the evening progress notes of a specified day in June 2013, that Resident #1 got out of bed to go beside his/her roommate (Resident #7) and was touching him/her.

On July 24, 2013, Inspector #126 interviewed PSW S #118 regarding incident of the specified day in June 2013.
S #118 indicated that around 2100 hour, he/she observed Resident #1 beside the bed of Resident #7. He/she asked Resident #1 what he/she was doing there and Resident #1 answered that he/she wanted to have sex with Resident # 7. S #118 redirected Resident #1 to his/her bed.

Resident #7 was observed by S #118 to be resting quietly in bed covered with a blanket. Resident #1 was dressed with short and had no t-shirt on. S #118 indicated that he/she had not seen any inappropriate touching at that time, only Resident #1 making sexual comments. RPN S #114 and PSW S #118 talked with Resident #1 and told him/her that he/she did not have any right to touch Resident #7. No further incident was observed or reported and Resident #1 stayed in bed.

This incident was not reported to the Director or via CIR. An Internal critical incident report was completed that same day S #114. The Power of Attorney (POA) of Resident #7 and the police were not immediately informed of that Incident, they were notified the following day.

In addition to the above incidents of sexual abuse, Resident #1 was observed on several occasions demonstrating inappropriate behaviors between 2011 and 2013 which could have led to potential sexual abuse.

The Licensee did not protect Resident #3, #6, #7 from sexual abuse by Resident #1. The licensee did not implement effective interventions that would protect residents. The licensee did not immediately report every alleged, suspected or witnessed sexual abuse incidents as per legislative requirements. [s. 19. (1)] (126)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 23, 2013

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 2nd day of August, 2013

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LINDA HARKINS

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