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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 19, 2015	2015_347197_0033	O-002721-15, O-002529-15, O-002639-15	Critical Incident System

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Trillium Retirement and Care Community
800 EDGAR STREET KINGSTON ON K7M 8S4

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

JESSICA PATTISON (197), SARAH GILLIS (623)

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): September 28 - October 2, 2015

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care (DOC), the Assistant Directors of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN) and Personal Support Workers (PSW).

Inspectors also reviewed resident health care records, policies and staff education related to abuse and responsive behaviours and observed residents and resident care.

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

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **5 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	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). 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. Related to Log #O-002639-15:

The licensee has failed to protect Residents #002, #009 and #010 from sexual abuse by Resident #001.

Sexual abuse is defined in the Long Term Care Homes Act, S.O. 2007, Chapter 8, s. 2 (1) as "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".

The After Hours Pager was called by the home on a specified date to advise the Director that staff had witnessed Resident #001 sexually abuse Resident #002. A Critical Incident report was later submitted with more detail.

A review of the health care record for Resident #001 indicated specific information regarding the resident's cognitive status and mobility.

A review of Resident #001's progress notes revealed the following information:

1. RPN #108 noted that on a specified date during room checks at 0100 hours, a PSW indicated that Resident #009 was sitting on the side of Resident #001's bed. The PSW noted that Resident #001 was inappropriately touching Resident #009's . The note states that RN and ADOC were notified.

RPN #108 who wrote the progress note was interviewed and stated that she felt this was sexually abusive behaviour toward Resident #009 because the resident would not be able to consent, which is why she notified the RN on duty and ADOC on call.

2. Resident #001 was noted by RN #107 on another date to kiss Resident #002 on the lips. The note states that the nurse on call was notified, who then requested 1:1 for the remainder of the evening and night shift. The note states that 1:1 could not be provided on the night shift, so fifteen minute checks were implemented.

Upon review of Resident #002's progress notes, RN #107 wrote that she spoke to the Resident and the resident confirmed being kissed by Resident #001. When asked if the kiss was wanted, the resident indicated no. The note then indicates that the RN notified the ADOC.

RN #107 was interviewed vaguely remembered the incident. She was unable to speak to interventions that are in place to protect residents from sexually abusive behaviour and

was not aware of any other incidents between these two residents, other than one where a critical incident was submitted.

3. RN #122 noted that Resident #001 was kissing Resident #002 on a particular date and that redirection was provided. Resident #002 was noted to have no adverse reaction and the note indicates that the on-call nursing manager was notified.

After this incident, the Nurse Practitioner (NP) noted that a medication change would be made and Resident #001 would be reassessed in 3-5 days.

4. RN #123 wrote on another occasion that Resident #001 was observed by dietary staff making physical advances towards Resident #002, who was heard by staff telling Resident #001 "no" but the resident continued to make advances and was reported to have said "you'll be sorry." Staff removed Resident #001 from the dining room with a reminder that this behavior is not acceptable and will not be tolerated. The note indicates that Resident #001 is unable to appreciate the consequences of these actions and as such the matter will be monitored by internal processes. The note also states that staff contacted ADOC to inform of incident when calling about another issue within the facility.

A Care Conference Summary indicated that Resident #001 continues to have inappropriate, sexual behavior towards co-resident, that the resident becomes obsessed. The note further indicates that there are “no health concerns” and “no referrals required at this time”.

5. RPN #110 indicates that on a specified date she was walking down the hall and noted Resident #001, with arms wrapped around Resident #002 (shoulder area) and was kissing the resident. Resident #001 was removed by staff and PSW removed Resident #002. The note says that Resident #002’s pants were down past his/her hips and brief was intact. RPN explained to Resident #001 that kissing or touching another resident was not acceptable. The RPN writes that Resident #001 did not appear to understand what writer was talking about.
RPN #110 was interviewed on September 30, 2015 and stated that she would not describe the behaviours she has witnessed from Resident #001 as sexually abusive. She also stated that she did not believe there had been any further issues with Resident #001 since Resident #002 had been moved.

6. RN #109 writes that on a particular evening, Resident #001, in the dining-room during supper, was grabbing at and kissing Resident #002, who was trying to push Resident

#001 away. Staff intervened and nothing further transpired.

RN #109 was interviewed on October 1, 2015 and stated that she never actually witnessed an incident with Resident #001 but overheard a PSW intervene once and by the time she arrived the residents had been separated. She also stated she vaguely remembered an incident in the dining room. She stated that she would not call what occurred on August 12, 2015 sexually abusive behaviour. When asked what interventions are in place related to Resident #001's behaviours, she stated they just keep a close eye on the resident. She stated that she does not see Resident #001 as a danger to other residents and she never felt that Resident #002 was distressed by Resident #001's actions.

7. RN #123 writes that Resident #001 was noted to be sexually inappropriate towards Resident #002 two times on another specified date. Interventions were noted as - residents have been separated and one to one observation to prevent further behaviours. The nurse manager was contacted and the RN was directed to contact the resident's POA, as well as the police to report the incident. The ADOC notified the Administrator and completed a formal report. The note further indicates that the RN informed the resident that people will be coming in to discuss what happened and Resident #001 stated "oh about me touching that resident?" RN #123 writes that at this point it is clear that this resident is aware of behaviour but lacks the insight into it being inappropriate.

RN #123 could not be reached for interview, but PSW #105 who witnessed the incident was interviewed on October 2, 2015. She stated that she was coming down the hall towards the lounge when she saw Resident #002 in the doorway of the lounge trying to get out and Resident #001 was blocking the resident's exit and was touching the resident inappropriately. PSW #105 states that Resident #002 was trying to push Resident #001's hands away.

PSW #105 states that once she separated the residents, Resident #002 went towards the other home area and was by the safety doors. PSW #105 took Resident #001 down towards his/her room and then went to report the incident to RN #123.

Approximately 10-15 minutes later, PSW #105 says she was bringing another resident into the dining room when she heard another resident yelling out. Upon entering the dining room she saw that Resident #001 was holding Resident #002's head in place, forcing a kiss. Again, she separated the two residents and took Resident #001 back to his/her room and was given dinner there because she did not feel it was safe to have

Resident #001 in the dining room.

PSW #105 again reported the incident to RN #123 who called the manager on duty.

PSW #105 went on to say that it was a very busy time as they have to porter many residents to the dining room for supper. She states she has witnessed other sexual behaviors from Resident #001 and she states she reported these incidents to Registered staff each time they occurred. She states the only time she filled out an internal incident report was on a specified date and a copy was given to the police.

When asked what was in place to protect other residents from Resident #001's sexual behaviours, PSW #105 said the only thing is to re-direct the resident. She states she has spoken to Resident #001 and things are fine for a couple days but said it's hard to monitor closely around supper time with many other residents to assist.

When asked if she felt Resident #001's behaviour was well managed before the specified date, she said she was extremely concerned for Resident #002, indicating that the resident does not communicate well, making the resident more vulnerable. She stated that many times she told nursing staff that it was her responsibility to protect Resident #002 and she felt like they were failing the resident.

RN #106 documented on an Interdisciplinary Care Conference Summary that Resident #001 was sexually inappropriate on multiple occasions when attempting to kiss other residents. Medications have been adjusted to help with this issue. The summary also indicates that the resident does not always remember messages from staff and others. The nursing goal is that the resident will have improved behaviours and not be sexually inappropriate.

8. RN #106 writes on another date that PSW staff observed Resident #001 and Resident #010 kissing. Resident #001 had a hand behind Resident #010's head and their lips were touching. Staff intervened immediately and separated the residents. RN indicated in the progress note that it does meet the criteria for CIS report and that Nurse manager on call notified five minutes after the incident.

PSW #104 observed incident and was interviewed. She stated that she saw Resident #001 physically grab Resident #010, pull the resident forward and kissed them. She said she did not feel this was consensual and she would classify this as sexually abusive behaviour. She said that Resident #001 had a good grip on Resident #010 and pulled

them in. PSW #104 states she had to physically pull Resident #001 away from Resident #010 and Resident #001 was angry with the PSW when she did this. When asked what interventions are in place to protect other residents from Resident #001's sexually abusive behaviour she stated re-direction and monitoring.

RN #106 was interviewed and stated that she wasn't sure if Resident #010 would have wanted Resident #001's kiss and feels it could have been sexual abuse. She indicated that she reported the incident to management and they would have decided what reporting was necessary.

It was also noted by the Inspector when reviewing the progress notes that there were seventeen other incidents over a 10 month period where Resident #001 attempted to kiss or touch other residents, thirteen of which were directed towards Resident #002.

Only one incident of sexually abusive behaviour by Resident #001 was reported to the Police and the Director (Ministry of Health and Long-Term Care). There is no evidence that an investigation occurred for any of the other incidents or that follow-up was done and changes were made (other than some medication changes) to ensure other residents, particularly Resident #002, were protected.

On October 2, 2015, ADOC #116, the Director or Care (DOC) and Administrator were all interviewed separately.

ADOC #116 stated that she was unaware of many of the incidents noted in the progress notes of Resident #001. Upon reading the progress notes with the Inspector she agreed that some of the incidents should have been reported and investigated. ADOC #116 stated that up until this point there had not been a referral for Resident #001 to the Psychogeriatric Outreach Team, but that they would complete one now. In relation to what occurred on the date when the home submitted the Critical Incident, ADOC #116 indicated that her expectation would have been for staff to be watching Resident #001 after the first incident with Resident #002 in order to ensure nothing further happened.

The DOC stated that she too was unaware of many of the incidents of sexually abusive behaviour towards other residents in Resident #001's progress notes. She indicated that she was aware that Resident #001 was fixated on Resident #002 and the resident had one:one supervision after a specified incident. The DOC stated that she felt staff should have kept a closer eye on Resident #001 the evening of the Critical Incident after the first occurrence, so that Resident #001 could not continue to pursue Resident #002. The

DOC went on to say that after looking at the progress notes with all of the incidents, it seemed like Resident #001's actions were "predatory" and that they will need to look at further interventions to manage the resident's behaviours. The DOC agreed that the plan of care for Resident #001 should have better interventions for how staff should manage Resident #001's behaviours and recognized that no behavioural triggers were identified.

The Administrator reviewed the progress notes with the Inspector and and also indicated that she was unaware of most of the incidents. She stated that some of them should have been reported and stated that they were not reported to the Ministry of Health or the Police and that investigations were not conducted.

In a telephone interview on October 6, 2015, the Administrator indicated that they had initiated a Psychogeriatric referral for Resident #001 and had begun their own investigation into the incidents that were not reported. She also indicated that Resident #001's plan of care was being reviewed and revised to manage the resident's sexual behaviours.[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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. Related to Log #O-002639-15:

The licensee has failed to comply with LTHCA 2007, s. 6(11)(b) in that different

approaches were not considered in the revision of Resident #001's plan of care when the care set out in the plan of care had not been effective.

Resident #001 was sexually abusive 8 times towards co-residents and attempted to inappropriately touch co-residents 17 times over a 10 month period.

The current care plan was reviewed for Resident #001.

Multiple staff members were interviewed in relation to Resident #001's responsive behaviours.

PSW #119 stated that staff have to be firm with Resident #1 and re-direct when displaying sexual behaviour. When asked what other interventions are in place she stated that re-direction was the only one she was aware of.

PSW #105 stated that interventions for Resident #001 related to sexual behaviours are to re-direct the resident, which is successful for the most part. She also stated she is concerned for the safety of other residents because the staff do have to constantly monitor Resident #001.

RN #107 stated that she is unaware of any specific provisions in place to protect residents from Resident #001's sexual behaviours. She stated she was only aware of a few incidents recently with Resident #002.

PSW #105 stated she witnessed an incident that occurred between Resident #001 and Resident #002 on a specified date and that she felt like they (staff) were failing to protect Resident #002. She further indicated that there are no instructions from nursing for what PSW staff should do when Resident #001 is displaying sexual behaviours, other than re-direction. On a specified night, she took it upon herself to give Resident #001 a meal in his/her room because she didn't feel it was safe for the resident to be in the dining room with other residents. She further stated that a new specified intervention was mentioned to her after this incident.

RN #109 stated that staff keep an eye on Resident #001 and she is not aware of any other interventions related to sexual behaviours towards other residents.

RPN #110 stated that interventions for Resident #001 are to re-direct and monitor and that she is not aware of any further sexual behaviours.

A Care Conference Summary indicated that Resident #001 has continued to have inappropriate, sexual behavior towards co-resident, that the resident becomes obsessed. The note further indicates that there are no health concerns and that no referrals are required at this time.

On another date, RN #106 documented on an Interdisciplinary Care Conference Summary that Resident #001 was sexually inappropriate on multiple occasions when attempting to kiss other residents. Medications have been adjusted to help with this issue. The summary also indicates that the resident does not always remember messages from staff and others. The nursing goals is that the resident will have improved behaviours and not be sexually inappropriate.

Different approaches have not been considered when reviewing Resident's #001's plan of care to manage sexual behaviours. Current interventions do not instruct staff how to re-direct or distract the resident when acting in a sexually abusive manner and it does not specify how and when staff are to monitor the resident. Staff were unaware of what to do when re-direction was not successful. [s. 6. (11) (b)]

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 different approaches are considered in the revision of Resident #001's plan of care when the care set out in the plan of care had not been effective, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. Related to Log #O-002639-15:

The licensee has failed to comply with LTCHA 2007, s. 20(1) in that they did not comply with their policy to promote zero tolerance of abuse and neglect of residents.

The home's policy titled "Prevention of Abuse & Neglect of a Resident", last updated January 2015 states the following:

- All employees, volunteers, agency staff, private duty care givers, contracted service providers, residents, and families are required to immediately report and suspected or known incident of abuse or neglect to the Director of MOHLTC and the Executive Director/Administrator or designate in charge of the home.

- The Charge Nurse will:
6) Document the current resident status on the resident's record and complete a Critical Incident Report.
7) Update the care plan as appropriate, ensuring that direct care staff are made aware of current resident status

- The ED/Administrator or designate, at the time of immediate notification by staff will:
2) Immediately notify the Police of any alleged, suspected, or witnessed incident of abuse or neglect of a resident which may constitute a criminal offence.

- The investigation
1) The Executive Director/Administrator or designate initiates the investigation by requesting that anyone aware of or involved in the situation write, sign, and date a statement accurately describing the event, reiterating anonymity and protection against retaliation.
3) The written statements are obtained as close to the time of the event as possible.
4) All investigative information is kept in a separate report from the resident's record.
10) An inter-professional Team Debriefing meeting must be arranged as soon as feasible to debrief the events of the incident, discuss strategies to prevent reoccurrence, reivew and revise resident care plan as needed, and communicate results with the resident/POA.

The home did not follow their policy in that:

- Over a 10 month period, 7 suspected or known incidents of sexual/emotional abuse of a resident were not reported to the Director.
- For these same incidents, the Charge Nurse did not complete a Critical Incident Report and did not update Resident #001's care plan to ensure that direct care staff were made aware of the current resident status
- At the time of the immediate notification by staff, the designate (manager on duty) did not call the police when the incident(s) may have constituted a criminal offence
- The home could not provide any evidence of investigation documentation for any of the 7 incidents that occurred with Resident #001 over the 10 month period or that a an inter-professional Team Debriefing meeting was arranged to debrief the events of the incidents, discuss strategies to prevent re-occurrence and review and revise Resident #001's care plan as needed. [s. 20. (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 compliance with the home's "Prevention of Abuse & Neglect of a Resident" policy, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. Related to Log #O-002639-15:

The licensee has failed to comply with LTCHA 2007, s. 23 (1)(a) in that not every alleged, suspected or witnessed incident of sexual abuse of a resident that the licensee knows of, or that is reported is immediately investigated.

As per WN #1, over a 10 month period, 8 incidents of sexual abuse towards co-residents by Resident #001 were noted in the resident's progress notes. The progress notes and staff interviews indicate that the manager on call was notified of the incidents. ADOC #116, the DOC and the Administrator all confirmed that investigations were not completed related to any of these incidents, except for one on a specified date. [s. 23. (1) (a)]

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 every alleged, suspected or witnessed incident of sexual abuse of a resident that the licensee knows of, or that is reported is immediately investigated, to be implemented voluntarily.

WN #5: 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. Related to Log #O-002639-15:

The licensee has failed to comply with LTHCA 2007, s. 24(1)2 in that the person who had reasonable grounds to suspect that abuse of a resident by another resident occurred or may occur, did not immediately report the suspicion and the information upon which it is based to the Director.

As per WN #1, Resident #001 was sexually abusive towards other residents in the home 8 times over a 10 month period. The progress notes and staff interviews indicate that the Manager on Duty was notified of the incidents. With the exception of one incident, no other incidents were 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 any person who has reasonable grounds to suspect that abuse of a resident by a resident occurred or may occur, immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 54(a) in that steps were not taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations.

Related to Log #O-002639-15:

The Placement Services Behavioural Assessment conducted by the South East Community Care Access Centre before admission of Resident #001 indicated that the resident had specified sexually inappropriate behaviours.

The initial care plan for Resident #001 did not identify any behaviour triggers for Resident

#001's inappropriate sexual behaviours and did not address the potential for sexual behaviour towards co-residents.

Over a 10 month period, Resident #001 was sexually abusive towards co-residents 8 times, with 17 other documented attempts that were stopped by staff who intervened. The health care record for Resident #001 was reviewed, including the current care plan.

Three Behavioural Tracking Tools were found in Resident #001's health care record, two of them incomplete.

There was no evidence of an interdisciplinary assessment related to these Behavioural Tracking Tools or any other observations of Resident #001.

Behavioural triggers related to Resident #001's sexual behaviour were not identified anywhere in Resident #001's health care record and when staff were interviewed they could only speak to what their personal opinion was of what triggered the resident's sexual behaviours.

Interventions that had been put into place up until the time of this inspection included monitoring, re-direction and medication changes. These interventions were not effective and on 8 occasions residents in the home were subjected to sexually abusive behaviour by Resident #001. [s. 54. (a)]

2. Related to Log #O-002529-15:

As per a Critical Incident on a specified date, Resident #004 was struck by Resident #003 resulting in a physical injury.

On September 29, 30 and October 1, 2015 the health record for Resident #003 was reviewed and the following information was provided:

-Resident #003 had a history of verbal and physical aggression/abuse towards Resident #004. There had been 16 episodes of Resident #003 yelling and swearing at multiple residents, nine of which were directed towards Resident #004.

On September 30 & October 1, 2015, interviews with PSW #100 and RN #102 confirmed that the plan of care for Resident #003 does not identify potential triggers for physical or verbal aggression. Staff are aware of the history between these residents and stated

"they just know from working with Resident #003 what they need to do to keep others safe". There is no documented evidence related to this information.

The plan of care in place for Resident #003 indicates that there is a potential for verbal aggression towards Resident #004 and to re-direct Resident #003 away from Resident #004 due to chances of verbal aggression towards each other.

Steps have not been taken to minimize the risk of physical altercations between Residents #003 and #004 and the plan of care for Resident #003 failed to identify factors that could potentially trigger physical aggression toward Resident #004.(623) [s. 54. (a)]

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 steps are taken to minimize the risk of altercations and potentially harmful interactions between residents, by identifying factors that could potentially trigger such altercations, to be implemented voluntarily.

WN #7: 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. Related to Log #O-002639-15:

The licensee has failed to comply with O. Reg. 79/10, s. 98 in that the appropriate police force was not notified of any alleged, suspected, or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence.

As per WN #1, a review of Resident #001's progress notes and staff interviews revealed that on 8 occasions over a 10 month period, Resident #001 was sexually abusive towards other residents in the home. The police were not called for 7 out of the 8 incidents. [s. 98.]

Issued on this 20th day of November, 2015

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

Ministére 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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA PATTISON (197), SARAH GILLIS (623)
Inspection No. / No de l'inspection :	2015_347197_0033
Log No. / Registre no:	O-002721-15, O-002529-15, O-002639-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 19, 2015
Licensee / Titulaire de permis :	The Royale Development GP Corporation as general partner of The Royale Development LP 302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Trillium Retirement and Care Community 800 EDGAR STREET, KINGSTON, ON, K7M-8S4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bonnie George

To The Royale Development GP Corporation as general partner of The Royale Development LP, 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) (b)

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 prepare, submit and implement a plan to include the following:
1) The development of a monitoring process to ensure:
a) Every alleged, suspected or witnessed incident of sexual abuse is immediately investigated.
b) The Director is immediately notified if there are reasonable grounds to suspect sexual abuse of a resident that resulted in harm or risk of harm to the resident.
c) The appropriate police force is immediately notified of any alleged, suspected, or witnessed incident of sexual abuse that may constitute a criminal offense.
d) Communication between direct care staff and management is on-going in relation to Resident #001's sexual behaviours and that steps are taken to identify the resident's behavioural triggers and to put interventions into place to mitigate the risks associated with these behaviours.
e) When Resident #001 is reassessed because the care set out in the plan of care has not been effective, different approaches shall be considered in the revision of the plan until success is achieved.

2) Re-education of staff and management to include:
a) Identification of incidents/actions that constitute sexual abuse.
b) Legislated reporting and investigation requirements of all incidents of alleged, suspected or witnessed incidents of abuse, with a particular focus on incidents involving cognitively impaired residents.
c) Review of the home's prevention of abuse policy to ensure that reporting and investigation procedures are complied with.

This plan shall identify the timeline and person(s) responsible for completing each task and shall be faxed to Jessica Pattison at 613-569-9670 by November 27, 2015.

Grounds / Motifs :

1. Related to Log #O-002639-15:

The licensee has failed to protect Residents #002, #009 and #010 from sexual abuse by Resident #001.

Sexual abuse is defined in the Long Term Care Homes Act, S.O. 2007, Chapter 8, s. 2 (1) as "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".

The After Hours Pager was called by the home on a specified date to advise the Director that staff had witnessed Resident #001 sexually abuse Resident #002. A Critical Incident report was later submitted with more detail.

A review of the health care record for Resident #001 indicated specific information regarding the resident's cognitive status and mobility.

A review of Resident #001's progress notes revealed the following information:

1. RPN #108 noted that on a specified date during room checks at 0100 hours, a PSW indicated that Resident #009 was sitting on the side of Resident #001's bed. The PSW noted that Resident #001 was inappropriately touching Resident #009's . The note states that RN and ADOC were notified.

RPN #108 who wrote the progress note was interviewed and stated that she felt this was sexually abusive behaviour toward Resident #009 because the resident would not be able to consent, which is why she notified the RN on duty and ADOC on call.

2. Resident #001 was noted by RN #107 on another date to kiss Resident #002 on the lips. The note states that the nurse on call was notified, who then requested 1:1 for the remainder of the evening and night shift. The note states that 1:1 could not be provided on the night shift, so fifteen minute checks were implemented.

Upon review of Resident #002's progress notes, RN #107 wrote that she spoke to the Resident and the resident confirmed being kissed by Resident #001. When asked if the kiss was wanted, the resident indicated no. The note then indicates that the RN notified the ADOC.

RN #107 was interviewed vaguely remembered the incident. She was unable to speak to interventions that are in place to protect residents from sexually abusive behaviour and was not aware of any other incidents between these two residents, other than one where a critical incident was submitted.

3. RN #122 noted that Resident #001 was kissing Resident #002 on a particular date and that redirection was provided. Resident #002 was noted to have no

adverse reaction and the note indicates that the on-call nursing manager was notified.

After this incident, the Nurse Practitioner (NP) noted that a medication change would be made and Resident #001 would be reassessed in 3-5 days.

4. RN #123 wrote on another occasion that Resident #001 was observed by dietary staff making physical advances towards Resident #002, who was heard by staff telling Resident #001 "no" but the resident continued to make advances and was reported to have said "you'll be sorry." Staff removed Resident #001 from the dining room with a reminder that this behavior is not acceptable and will not be tolerated. The note indicates that Resident #001 is unable to appreciate the consequences of these actions and as such the matter will be monitored by internal processes. The note also states that staff contacted ADOC to inform of incident when calling about another issue within the facility.

A Care Conference Summary indicated that Resident #001 continues to have inappropriate, sexual behavior towards co-resident, that the resident becomes obsessed. The note further indicates that there are “no health concerns” and “no referrals required at this time”.

5. RPN #110 indicates that on a specified date she was walking down the hall and noted Resident #001, with arms wrapped around Resident #002 (shoulder area) and was kissing the resident. Resident #001 was removed by staff and PSW removed Resident #002. The note says that Resident #002’s pants were down past his/her hips and brief was intact. RPN explained to Resident #001 that kissing or touching another resident was not acceptable. The RPN writes that Resident #001 did not appear to understand what writer was talking about. RPN #110 was interviewed on September 30, 2015 and stated that she would not describe the behaviours she has witnessed from Resident #001 as sexually abusive. She also stated that she did not believe there had been any further issues with Resident #001 since Resident #002 had been moved.

6. RN #109 writes that on a particular evening, Resident #001, in the dining-room during supper, was grabbing at and kissing Resident #002, who was trying to push Resident #001 away. Staff intervened and nothing further transpired.

RN #109 was interviewed on October 1, 2015 and stated that she never actually witnessed an incident with Resident #001 but overheard a PSW intervene once

and by the time she arrived the residents had been separated. She also stated she vaguely remembered an incident in the dining room. She stated that she would not call what occurred on August 12, 2015 sexually abusive behaviour. When asked what interventions are in place related to Resident #001's behaviours, she stated they just keep a close eye on the resident. She stated that she does not see Resident #001 as a danger to other residents and she never felt that Resident #002 was distressed by Resident #001's actions.

7. RN #123 writes that Resident #001 was noted to be sexually inappropriate towards Resident #002 two times on another specified date. Interventions were noted as - residents have been separated and one to one observation to prevent further behaviours. The nurse manager was contacted and the RN was directed to contact the resident's POA, as well as the police to report the incident. The ADOC notified the Administrator and completed a formal report. The note further indicates that the RN informed the resident that people will be coming in to discuss what happened and Resident #001 stated "oh about me touching that resident?" RN #123 writes that at this point it is clear that this resident is aware of behaviour but lacks the insight into it being inappropriate.

RN #123 could not be reached for interview, but PSW #105 who witnessed the incident was interviewed on October 2, 2015. She stated that she was coming down the hall towards the lounge when she saw Resident #002 in the doorway of the lounge trying to get out and Resident #001 was blocking the resident's exit and was touching the resident inappropriately. PSW #105 states that Resident #002 was trying to push Resident #001's hands away.

PSW #105 states that once she separated the residents, Resident #002 went towards the other home area and was by the safety doors. PSW #105 took Resident #001 down towards his/her room and then went to report the incident to RN #123.

Approximately 10-15 minutes later, PSW #105 says she was bringing another resident into the dining room when she heard another resident yelling out. Upon entering the dining room she saw that Resident #001 was holding Resident #002's head in place, forcing a kiss. Again, she separated the two residents and took Resident #001 back to his/her room and was given dinner there because she did not feel it was safe to have Resident #001 in the dining room.

PSW #105 again reported the incident to RN #123 who called the manager on

duty.

PSW #105 went on to say that it was a very busy time as they have to porter many residents to the dining room for supper. She states she has witnessed other sexual behaviors from Resident #001 and she states she reported these incidents to Registered staff each time they occurred. She states the only time she filled out an internal incident report was on a specified date and a copy was given to the police.

When asked what was in place to protect other residents from Resident #001's sexual behaviours, PSW #105 said the only thing is to re-direct the resident. She states she has spoken to Resident #001 and things are fine for a couple days but said it's hard to monitor closely around supper time with many other residents to assist.

When asked if she felt Resident #001's behaviour was well managed before the specified date, she said she was extremely concerned for Resident #002, indicating that the resident does not communicate well, making the resident more vulnerable. She stated that many times she told nursing staff that it was her responsibility to protect Resident #002 and she felt like they were failing the resident.

RN #106 documented on an Interdisciplinary Care Conference Summary that Resident #001 was sexually inappropriate on multiple occasions when attempting to kiss other residents. Medications have been adjusted to help with this issue. The summary also indicates that the resident does not always remember messages from staff and others. The nursing goal is that the resident will have improved behaviours and not be sexually inappropriate.

8. RN #106 writes on another date that PSW staff observed Resident #001 and Resident #010 kissing. Resident #001 had a hand behind Resident #010's head and their lips were touching. Staff intervened immediately and separated the residents. RN indicated in the progress note that it does meet the criteria for CIS report and that Nurse manager on call notified five minutes after the incident.

PSW #104 observed incident and was interviewed. She stated that she saw Resident #001 physically grab Resident #010, pull the resident forward and kissed them. She said she did not feel this was consensual and she would classify this as sexually abusive behaviour. She said that Resident #001 had a

good grip on Resident #010 and pulled them in. PSW #104 states she had to physically pull Resident #001 away from Resident #010 and Resident #001 was angry with the PSW when she did this. When asked what interventions are in place to protect other residents from Resident #001's sexually abusive behaviour she stated re-direction and monitoring.

RN #106 was interviewed and stated that she wasn't sure if Resident #010 would have wanted Resident #001's kiss and feels it could have been sexual abuse. She indicated that she reported the incident to management and they would have decided what reporting was necessary.

It was also noted by the Inspector when reviewing the progress notes that there were seventeen other incidents over a 10 month period where Resident #001 attempted to kiss or touch other residents, thirteen of which were directed towards Resident #002.

Only one incident of sexually abusive behaviour by Resident #001 was reported to the Police and the Director (Ministry of Health and Long-Term Care). There is no evidence that an investigation occurred for any of the other incidents or that follow-up was done and changes were made (other than some medication changes) to ensure other residents, particularly Resident #002, were protected.

On October 2, 2015, ADOC #116, the Director or Care (DOC) and Administrator were all interviewed separately.

ADOC #116 stated that she was unaware of many of the incidents noted in the progress notes of Resident #001. Upon reading the progress notes with the Inspector she agreed that some of the incidents should have been reported and investigated. ADOC #116 stated that up until this point there had not been a referral for Resident #001 to the Psychogeriatric Outreach Team, but that they would complete one now. In relation to what occurred on the date when the home submitted the Critical Incident, ADOC #116 indicated that her expectation would have been for staff to be watching Resident #001 after the first incident with Resident #002 in order to ensure nothing further happened.

The DOC stated that she too was unaware of many of the incidents of sexually abusive behaviour towards other residents in Resident #001's progress notes. She indicated that she was aware that Resident #001 was fixated on Resident #002 and the resident had one:one supervision after a specified incident. The

DOC stated that she felt staff should have kept a closer eye on Resident #001 the evening of the Critical Incident after the first occurrence, so that Resident #001 could not continue to pursue Resident #002. The DOC went on to say that after looking at the progress notes with all of the incidents, it seemed like Resident #001's actions were "predatory" and that they will need to look at further interventions to manage the resident's behaviours. The DOC agreed that the plan of care for Resident #001 should have better interventions for how staff should manage Resident #001's behaviours and recognized that no behavioural triggers were identified.

The Administrator reviewed the progress notes with the Inspector and and also indicated that she was unaware of most of the incidents. She stated that some of them should have been reported and stated that they were not reported to the Ministry of Health or the Police and that investigations were not conducted.

In a telephone interview on October 6, 2015, the Administrator indicated that they had initiated a Psychogeriatric referral for Resident #001 and had begun their own investigation into the incidents that were not reported. She also indicated that Resident #001's plan of care was being reviewed and revised to manage the resident's sexual behaviours.

The decision to issue a Compliance Order was based on the following:

Severity - Actual harm came to residents in that Resident #001 sexually abused three cognitively impaired residents, one on multiple occasions. Many of the incidents were communicated to the manager on duty, yet were not reported to the Director (WN #5) or the Police (WN #7) and no investigation took place (WN #4) to ensure the safety of other residents. The home's policy to promote zero tolerance of abuse was not complied with (WN #3).

In relation to the Resident's responsive behaviours, when Resident #001 was reassessed due to care set out in the plan of care not being effective, different approaches were not considered in the revision of the plan (WN # 2). The home also did not ensure that that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents by identifying factors that could potentially trigger such altercations (WN #6).

Scope - Three residents were sexually abused by Resident #001.

Compliance History - Over the last three years, the following non-compliances have been issued in the home: LTCHA 2007, s. 24 related to reporting abuse to the Director, LTCHA 2007, s. 20(1) related to following the home's abuse policy and LTCHA 2007, s. 6 related to plan of care (197)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 18, 2015

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 19th day of November, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jessica Pattison

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