

## Order(s) of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	<input type="checkbox"/> Licensee Copy/Copie du Titulaire <span style="margin-left: 100px;"><input checked="" type="checkbox"/> Public Copy/Copie Public</span>
<b>Name of Director:</b>	Lynne Haves
<b>Order Type:</b>	<input type="checkbox"/> Amend or Impose Conditions on Licence Order, section 104 <input type="checkbox"/> Renovation of Municipal Home Order, section 135 <input checked="" type="checkbox"/> Compliance Order, section 153 <input type="checkbox"/> Work and Activity Order, section 154 <input type="checkbox"/> Return of Funding Order, section 155 <input type="checkbox"/> Mandatory Management Order, section 156 <input type="checkbox"/> Revocation of License Order, section 157 <input type="checkbox"/> Interim Manager Order, section 157
<b>Intake Log # of original inspection (if applicable):</b>	007959-18, 018390-18, 018502-18
<b>Original Inspection #:</b>	2018_689586_0022
<b>Licensee:</b>	City of Hamilton 28 James Street North, 4th Floor, HAMILTON, ON, L8R-2K1
<b>LTC Home:</b>	Wentworth Lodge 41 South Street West, DUNDAS, ON, L9H-4C4
<b>Name of Administrator:</b>	Karen Allcroft

**Background:**

Ministry of Health and Long-Term Care (MOHLTC) Inspector #586 conducted a Critical Incident Systems (CIS) Inspection at Wentworth Lodge long-term care (LTC) home on August 29, 2018 and August 30, 2018. As part of the inspection, three intake logs were inspected (#007959-18, 018390-18 and 018502-18), which all related to the prevention of abuse and neglect.

During the inspection, the Inspector determined that the Licensee (Wentworth Lodge, LTC Home or the Licensee) failed to comply with subsection 19(1) of the Long-Term Care Homes Act, 2007 (LTCHA) and issued Compliance Order #001.

<b>Order #:</b>	001
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To **City of Hamilton**, you are hereby required to comply with the following order by the date set out below:

**Pursuant To:**

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:**

The licensee must be compliant with LTCHA s. 19 (1). Specifically, the licensee shall ensure all residents are protected from sexual abuse by anyone. The Licensee shall prepare, submit and implement a plan for achieving compliance with the requirement to protect all residents from abuse by anyone. The plan must be aimed at protecting residents from abuse. The plan must include safeguarding measures and intervention strategies to be implemented by staff when there are reasonable grounds to suspect abuse towards a resident.

**Grounds:**

The Licensee has failed to ensure that the resident was protected from sexual abuse.

O. Reg. 79/10, s. 2(1) defines sexual abuse as "... (b) 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 LTC home submitted a CIS report #M592-000012-18, log #018502-18, on an identified date in 2018. According to the CIS report and progress notes, a staff member went to the resident's room and witnessed a suspicious incident between the resident and a person other than the Licensee or a staff member. The staff member reported the incident to a registered staff member.

The resident went out of the home for several hours. Upon the resident's return, registered staff entered the resident's room to witness an incident of inappropriate sexual behaviour between the resident and the visitor. The incident was also witnessed by another staff member.

The above information was consistent with the LTC home's internal investigation notes of the incident as well as through interviews with three other staff members.

According to six staff members of the LTC home, the resident was unable to make informed decisions and was cognitively impaired. All individuals confirmed that the resident was unable to consent to the sexual act and that they were sexually abused by the person other than the Licensee and staff members.

The resident was interviewed and could not recall the incident.

**This order must be complied with by:** December 31, 2018

**REVIEW/APPEAL INFORMATION**

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

**Health Services Appeal and Review Board**  
Attention Registrar  
151 Bloor Street West  
9th Floor  
Toronto, ON  
M5S 2T5

and the

**Director**  
c/o Appeals Clerk  
Long-Term Care Inspections Branch  
1075 Bay St., 11th Floor, Suite 1100  
Toronto ON M5S 2B1  
Fax: 416-327-7603



**Ministry of Health and Long-Term Care**  
Long-Term Care Homes Division  
Long-Term Care Inspections Branch

**Ministère de la Santé et des Soins de longue durée**  
Division des foyers de soins de longue durée  
Inspection de soins de longue durée

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](http://www.hsarb.on.ca).

Issued on this 7th day of December, 2018	
Signature of Director:	
Name of Director:	Lynne Haves