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
Oct 8, 2013	2013_220111_0016	000461, 000467, 000598	Follow up

Licensee/Titulaire de permis

THE WEXFORD RESIDENCE INC.
1860 Lawrence Avenue East, TORONTO, ON, M1R-5B1

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

THE WEXFORD
1860 LAWRENCE AVENUE EAST, SCARBOROUGH, ON, M1R-5B1

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

Ontario

Ministry of Health and Long-Term Care

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The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): July 30, 31, August 12, 26, 27, 28, 29 and September 18, 2013.

There were four critical incident inspections (log# 000753, 000598, 000467, and 002415) that were completed concurrently with this follow-up(#000461) inspection. Critical incident inspection (log # 000753) was completed by Inspector # 166.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care (DOC), the physician, family members of Resident #9, 1 housekeeper, Registered Nurses (RN), Registered Practical Nurses(RPN), Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspector(s) reviewed health records of 9 residents, observed 9 residents, reviewed the home policies on Zero Tolerance of Abuse,Code White, Management of Responsive Behaviours, staff training records on Prevention of Abuse, management of Responsive Behaviours, and Code White.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to protect residents from abuse as shown by the following:

The licensee failed to protect residents, in particular Resident #2, #3 and #6, from physical abuse by other residents. The applicable definition of physical abuse in O.Reg. 79/10 of the LTCHA is "the use of physical force by a resident that causes physical injury to another resident".

2. The licensee failed to protect residents, in particular Resident #6 and #8 from sexual abuse. The applicable definition of sexual abuse in O.Reg. 79/10 of the LTCHA is "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".

3.On May 22, 2013 a Compliance Order was issued for s.19(1) under the LTCHA, 2007 which included s. 6(1)&(10) under the LTCHA, 2007 during inspection # 2013_220111_0006 and was to be complied with by June 30, 2013.

4.The severity of the harm and risk of harm to residents arising from the non-compliance was very high as Resident #1 had been physically abusive to at least 4 residents (Resident #2, #3, #5 and one unknown). Resident #6 had been a recipient of sexual abuse by Resident #10 and no action was taken.

5. The scope of the harm and risk of harm arising from the non-compliance is widespread. All residents are at risk of harm where the Licensee fails to protect them from abuse by other residents demonstrating responsive behaviours of physical and/or sexual aggression and/or abuse. In the specific circumstances involving Resident #1, at least 4 residents were at risk of harm or actually harmed by Resident #1 as identified in the inspection report. Resident #6 was also at risk of harm or actually harmed by Resident #10 as identified in the inspection report.

6.Related to log # 000467:
-Clinical documentation for Resident #6 indicated the resident had an incident of suspected sexual abuse by Resident #10 and there was no indication what time the incident occurred, whether the resident was assessed, or whether the physician and SDM were notified.
-Clinical documentation for Resident #10 had no documented evidence of the incident.

-The Plan of Care for Resident #10 indicated the resident had responsive behaviours of wandering but there was no clear direction to staff and others who provide direct care to Resident#10 related to potential for sexual inappropriate behaviours. Refer to the written notification of non-compliance under s.6(1)(c) of the LTCHA.
-The Plan of Care for Resident #6 did not provide clear direction to staff and others who provide direct care to Resident#6, on how staff would protect the resident from potential sexual abuse from Resident #10.Refer to the written notification of non-compliance under s.6(1)(c) of the LTCHA.
-There was no indication when Resident#6 was reassessed, the plan of care was revised when the resident's care needs changed (when the resident was the recipient of suspected sexual abuse). Refer to the written notification of non-compliance under s.6(10)(b)of the LTCHA.

7. Related to log # 000598:
-A Critical Incident report (CI)was submitted for an incident of resident to resident assault between Resident #1 and Resident #3 resulting in injury.
-Clinical documentation for Resident #1 indicated the resident had prior physical aggression and/or abuse with Resident #2, #3, #5, and one unknown resident.
-Review of the Plan of Care for Resident #1 related to Responsive Behaviours had no indication of a known trigger to the resident's physical aggression or strategies to manage this behaviour.
-There was no indication that when the care set out in the plan was not effective in reducing the resident's aggression (especially a known trigger), and when the resident was reassessed, alternative interventions were considered. Refer to the written notification of non-compliance under s.6(10)(b)(c)of the LTCHA.
-There was also no indication when the strategy suggested was refused, that alternatives were considered to manage the resident's responsive behaviours of physical aggression until the resident was admitted to hospital. Refer to written notification for non-compliance under s. 53(4)(a)(b) under O.Reg. 79/10. [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. 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 :

The licensee was issued non-compliance (written notification and voluntary plan of correction) for S. 24(1) on August 12, 2013 during inspection # 2013_195166_0019 and on September 12, 2013 during inspection # 2013_195166_0028.

2. Related to log # 000598:

A Critical incident report (CI) was submitted for an incident of resident to resident abuse between Resident #5 and Resident #1. The CI was amended eight days later indicating a second incident of suspected resident to resident sexual abuse had occurred between Resident #5 and another co-resident. There was no indication of who the co-resident was, the date or time the incident occurred, who witnessed or was involved in the incident, and what actions were taken.

Clinical documentation of Resident #5 indicated there were 3 separate incidents of suspected resident to resident sexual abuse that occurred towards Resident #8 and the Director was not notified for eight days.

3. Related to log # 000467:

Clinical documentation of Resident #6 indicated an incident of suspected resident to resident sexual abuse had occurred with Resident #10.

Interview of the DOC indicated an incident of suspected resident to resident sexual abuse occurred and the incident was not reported to the Director[s.24(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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

The licensee was issued non-compliance (written notification)for S. 107 on August 12, 2013 during inspection # 2013_195166_0019 and on October 8, 2013 during inspection # 2013_220111_0015.

Related to log # 000598:

A Critical incident report (CI) was submitted to the Director for an incident of resident to resident physical abuse that occurred between Resident #1 and Resident #5. The CI was amended eight days later indicating a second incident of suspected resident to resident sexual abuse had occurred between Resident #5 and another resident.

The Clinical documentation for Resident #5 indicated that there were 3 separate incidents of resident to resident sexual abuse that occurred over a 3 day period between Resident #5 and Resident #8.

The CI that was submitted to the Director did not indicate that there were 3 separate incidents of resident to resident sexual abuse, and did not include the dates and times of the incidents. [s. 107. (4) 1.]

2. The CI did not indicate Resident#8 who was the recipient of the resident to resident sexual abuse, or the staff members who discovered or responded to the incidents. [s. 107. (4) 2.]

3. There was no indication Resident #8 was assessed and actions were taken to protect Resident #8 from Resident #5. [s. 107. (4) 3.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 was issued non-compliance (written notification and voluntary plan of correction) for S. 98 on May 22, 2013 during inspection # 2013_220111_0006, on August 12, 2013 during inspection # 2013_195166_0019 and on September 12, 2013 during inspection # 2013_195166_0028.

2. Related to log # 000467:

Clinical documentation for Resident #6 indicated a incident of suspected sexual abuse occurred between Resident #6 and Resident #10 and there was no indication the police were notified.

3. Related to log #000598:

Clinical documentation for Resident #1 indicated there were two incidents of resident to resident physical abuse that occurred: between Resident #1 and Resident #5; between Resident #1 and an unknown resident and there was no indication the police were contacted. A third incident of resident to resident physical abuse occurred between Resident #1 and Resident #2 and the police were not notified until the next day.

4. Related to log #000598:

Clinical documentation of Resident #5 indicated that there were 3 separate incidents of suspected sexual abuse that occurred between Resident #5 and Resident #8 and there was no indication the police was notified.

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

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Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. Related to log# 000598:

Clinical documentation of Resident #8 indicated there were three separate incidents of suspected sexual abuse that occurred between Resident #5 and Resident #8 and there was no documented evidence to indicate the Substitute Decision maker (SDM) of Resident #8 was notified.

Clinical documentation for Resident #5 indicated the SDM was not notified of incidents of suspected sexual abuse between Resident #5 and Resident #8 for a period of four days.

2. Related to log# 000467:

Clinical documentation for Resident #6 indicated an incident of suspected sexual abuse occurred between Resident #6 and Resident #10 and there was no evidence the SDM of either Resident #6 or Resident #10 were notified of suspected resident to resident sexual abuse.

The licensee failed to ensure the resident's substitute decision-maker, if any, and any other person specified by the resident, were notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in distress to the resident that could potentially be detrimental to the resident's health or well-being.

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 all resident's substitute decision makers,if any and any other person specified by the resident, are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being, to be implemented voluntarily.

WN #6: 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.A. Related to log # 000598:

The licensee failed to ensure that the plan of care for Resident #5 provided clear direction to staff related to responsive behaviours of physical aggression and/or abuse (between Resident #1 and Resident #5), wandering, and sexually inappropriate/abusive behaviours (between Resident #5 and Resident #8)[s.6(1)(c)].

B. Related to log # 000467:

Clinical documentation for Resident #6 and Resident #7 indicated Resident#7 was found being physically abusive towards Resident #6 resulting in injury to Resident #6.

Clinical documentation for Resident #6 was found with suspected sexual abuse from Resident #10 and there was no indication what time the incident occurred, whether the resident was assessed, or whether the physician and SDM were notified.There was documented evidence of the incident in the clinical documentation for Resident #10.

The Plan of Care for Resident #7 had no clear direction to staff and others who provide direct care to Resident #7 related to the responsive behaviours of physical aggression to indicate how staff would monitor the resident[s.6(1)(c)].

The plan of care for Resident #6 had no clear direction to staff and others who provide direct care to Resident#6 on how staff would protect the resident from physical and sexual abuse from Resident #10[s.6(1)(c)].

The Plan of Care for Resident #10 had no clear direction to staff and others who provide direct care to Resident#10 related to responsive behaviours of wandering and potential for sexually inappropriate behaviours[s.6(1)(c)].

C. Related to complaint Log # 000753:

Clinical documentation for Resident #9 indicated the resident had reported an alleged incident of staff to resident physical abuse, sexual abuse and theft.

The plan of care for Resident #9 failed to ensure that the written plan of care for Resident #9 provided clear direction to staff and others who provide direct care to the

resident on how to safely manage and respond to the resident, when the resident displayed suspicious and accusatory behaviours(166)[s.6(1)(c)].

D. Related to log #000598:

Clinical documentation of Resident #5 indicated that there were 3 separate incidents of resident to resident sexual abuse that occurred between Resident #5 and Resident #8.Clinical documentation of Resident #8 only indicated 2 incidents of resident to resident sexual abuse between Resident #5 and Resident #8.

The Plan of Care for Resident #8 did not provide clear direction to staff and others who provide direct care to Resident#8, on how staff would protect the resident from potential sexual abuse from Resident #5.

The licensee failed to ensure that the written plan of care for Resident #8 provided clear direction to staff and others who provide direct care to the resident on how to prevent recurrence of sexual abuse by Resident #5[s.6.(1)(c)].

2. The licensee failed to comply with s.6(10)(b)(c) in that it failed to ensure that the plan of care was revised when the resident's care needs changed or, when the care set out in plan was not effective.

A.Related to log #000598:

(Refer to clinical documentation for Resident #5 section A under s.6(1)(c)).

When Resident #5 continued to demonstrate responsive behaviours of wandering and sexual inappropriateness towards Resident #8, there was no indication when the plan of care was reviewed and revised, that alternative interventions were considered when the wandering and sexually inappropriate behaviours continued and the interventions utilized were ineffective[s.6(10)(b)].

B. Related to log #000467:

(Refer to clinical documentation for Resident #6 section B under s.6(1)(c)).

There was no indication when Resident #6 care needs changed (was the recipient of

physical abuse from Resident #7 and recipient of suspected sexual abuse from Resident #10), the plan of care was revised when the care set out in the plan was not effective, or the strategies recommended by the interdisciplinary team to manage the resident's responsive behaviours of verbal/physical aggression were identified[s.6.(10)(b)(c)].

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. Related to log # 000598:

Clinical documentation for Resident #1 indicated the resident had demonstrated responsive behaviours of physical aggression and/or abuse towards Resident #2, #3, #5 and one unknown resident. Recommendations from the physician and the POP team were not considered to minimize triggers.

There was no indication of a known trigger to Resident #1's physical aggression and/or abuse, or strategies to manage this behaviour. There was also no indication when initial strategies offered to manage the residents responsive behaviour were refused, that alternatives were considered until the resident was admitted to hospital.

Ontario

Ministry of Health and Long-Term Care

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THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 96.	CO #002	2013_220111_0006	111

Issued on this 21st day of October, 2013

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

L. Brown

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2013_220111_0016
Log No. / Registre no:	000461, 000467, 000598
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Oct 8, 2013
Licensee / Titulaire de permis :	THE WEXFORD RESIDENCE INC. 1860 Lawrence Avenue East, TORONTO, ON, M1R-5B1
LTC Home / Foyer de SLD :	THE WEXFORD 1860 LAWRENCE AVENUE EAST, SCARBOROUGH, ON, M1R-5B1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SANDY BASSETT

To THE WEXFORD RESIDENCE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

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

Order # /
Ordre no : 001

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

Linked to Existing Order /
Lien vers ordre existant: 2013_220111_0006, CO #001;

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 :

To achieve compliance with the duty to protect residents from abuse by residents who demonstrate responsive behaviours of verbal and/or physical aggression and/or abuse, the Licensee shall:
1. Assess and/or reassess every resident identified as having demonstrated or demonstrating responsive behaviours of verbal, physical or sexual aggression and/or abuse toward others using the RAI-MDS assessment tool and any other assessment tool(s) specific to responsive behaviours, review and, if necessary, revise the plan of care based on the assessment(s);
2. Review and revise the plan of care for every resident identified as having demonstrated or demonstrating responsive behaviours of physical or sexual aggression and/or abuse toward others to ensure that the plan of care:
(i)provides clear direction to staff and others who provide direct care to the resident in the management of those responsive behaviours, including how to monitor and manage the responsive behaviours, and the direction must reflect the actual care provided related to responsive behaviours,
(ii) identifies behavioural triggers for the resident, where possible, including other residents with whom the resident has had one or more altercations,
(iii) identifies and documents strategies and interventions to respond to and manage the resident's responsive behaviours,
3. Where a resident demonstrates responsive behaviours of physical or sexual aggression and/or abuse toward another resident and the interventions are not effective because the behaviours are continuing, reassess the resident and review and revise the plan of care for the resident based on that assessment and ensure that different approaches are considered;
4. When one or more RAPS is triggered on a RAI-MDS assessment related to responsive behaviours of physical or sexual aggression and/or abuse, review and revise the plan of care set out based on the assessments.

The licensee shall comply with orders 2 & 3 immediately.

The licensee shall prepare, submit and implement a plan for complying with Orders 1 & 4 and identify who will be responsible for completing all of the tasks identified in these Orders and when the Orders will be complied with.

This plan is to be submitted to Lynda Brown by October 15, 2013 via email at Lynda.Brown2@ontario.ca.

Grounds / Motifs :

1. 1. The licensee failed to protect residents from abuse as shown by the following:

The licensee failed to protect residents, in particular Resident #2, #3 and #6, from physical abuse by other residents. The applicable definition of physical abuse in O.Reg. 79/10 of the LTCHA is "the use of physical force by a resident that causes physical injury to another resident".

2. The licensee failed to protect residents, in particular Resident #6 and #8 from sexual abuse. The applicable definition of sexual abuse in O.Reg. 79/10 of the LTCHA is "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".

3.On May 22, 2013 a Compliance Order was issued for s.19(1) under the LTCHA, 2007 which included s. 6(1)&(10) under the LTCHA, 2007 during inspection # 2013_220111_0006 and was to be complied with by June 30, 2013.

4.The severity of the harm and risk of harm to residents arising from the non-compliance was very high as Resident #1 had been physically abusive to at least 4 residents (Resident #2, #3, #5 and one unknown). Resident #6 had been a recipient of sexual abuse by Resident #10 and no action was taken.

5. The scope of the harm and risk of harm arising from the non-compliance is widespread. All residents are at risk of harm where the Licensee fails to protect them from abuse by other residents demonstrating responsive behaviours of physical and/or sexual aggression and/or abuse. In the specific circumstances involving Resident #1, at least 4 residents were at risk of harm or actually harmed by Resident #1 as identified in the inspection report. Resident #6 was also at risk of harm or actually harmed by Resident #10 as identified in the inspection report.

6.Related to log # 000467:
-Clinical documentation for Resident #6 indicated the resident had an incident of suspected sexual abuse by Resident #10 and there was no indication what time the incident occurred, whether the resident was assessed, or whether the physician and SDM were notified.
-Clinical documentation for Resident #10 had no documented evidence of the

incident.
-The Plan of Care for Resident #10 indicated the resident had responsive behaviours of wandering but there was no clear direction to staff and others who provide direct care to Resident#10 related to potential for sexual inappropriate behaviours. Refer to the written notification of non-compliance under s.6(1)(c) of the LTCHA.
-The Plan of Care for Resident #6 did not provide clear direction to staff and others who provide direct care to Resident#6, on how staff would protect the resident from potential sexual abuse from Resident #10.Refer to the written notification of non-compliance under s.6(1)(c) of the LTCHA.
-There was no indication when Resident#6 was reassessed, the plan of care was revised when the resident's care needs changed (when the resident was the recipient of suspected sexual abuse). Refer to the written notification of non-compliance under s.6(10)(b)of the LTCHA.

7. Related to log # 000598:
-A Critical Incident report (CI)was submitted for an incident of resident to resident assault between Resident #1 and Resident #3 resulting in injury.
-Clinical documentation for Resident #1 indicated the resident had prior physical aggression and/or abuse with Resident #2, #3, #5, and one unknown resident.
-Review of the Plan of Care for Resident #1 related to Responsive Behaviours had no indication of a known trigger to the resident's physical aggression or strategies to manage this behaviour.
-There was no indication that when the care set out in the plan was not effective in reducing the resident's aggression (especially a known trigger), and when the resident was reassessed, alternative interventions were considered. Refer to the written notification of non-compliance under s.6(10)(b)(c)of the LTCHA.
-There was also no indication when the strategy suggested was refused, that alternatives were considered to manage the resident's responsive behaviours of physical aggression until the resident was admitted to hospital. Refer to written notification for non-compliance under s. 53(4)(a)(b) under O.Reg. 79/10. [s. 19. (1)] (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 07, 2013

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

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. 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

The licensee shall ensure that a person who has reasonable grounds to suspect the abuse of a resident by anyone that resulted in harm or risk of harm to a resident, immediately reports the suspicion and the information upon which it's based, to the Director.

Grounds / Motifs :

1. The licensee was issued non-compliance (written notification and voluntary plan of correction) for S. 24(1) on August 12, 2013 during inspection # 2013_195166_0019 and on September 12, 2013 during inspection # 2013_195166_0028.

2. Related to log # 000598:

A Critical incident report (CI) was submitted for an incident of resident to resident abuse between Resident #5 and Resident #1. The CI was amended eight days later indicating a second incident of suspected resident to resident sexual abuse had occurred between Resident #5 and another co-resident. There was no indication of who the co-resident was, the date or time the incident occurred, who witnessed or was involved in the incident, and what actions were taken.

Clinical documentation of Resident #5 indicated there were 3 separate incidents of suspected resident to resident sexual abuse that occurred towards Resident #8 and the Director was not notified for eight days.

3. Related to log # 000467:

Clinical documentation of Resident #6 indicated an incident of suspected resident to resident sexual abuse had occurred with Resident #10.

Interview of the DOC indicated an incident of suspected resident to resident sexual abuse occurred and the incident was not reported to the Director[s.24(1)]. (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 09, 2013

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Order / Ordre :

The licensee will inform the Director within 10 days of of becoming aware of an incident under subsection (1) or (3) shall include:
-a description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
-a description of the individuals involved in the incident, including the names of any resident involved in the incident and names of any staff members or other persons who were present at or discovered the incident

The plan is to be submitted to Lynda Brown by October 15, 2013 via email at Lynda.Brown2@ontario.ca.

Grounds / Motifs :

1. The licensee was issued non-compliance (written notification)for S. 107 on August 12, 2013 during inspection # 2013_195166_0019 and on October 8, 2013 during inspection # 2013_220111_0015.

Related to log # 000598:

A Critical incident report (CI) was submitted to the Director for an incident of resident to resident physical abuse that occurred between Resident #1 and Resident #5. The CI was amended eight days later indicating a second incident of suspected resident to resident sexual abuse had occurred between Resident #5 and another resident.

The Clinical documentation for Resident #5 indicated that there were 3 separate incidents of resident to resident sexual abuse that occurred over a 3 day period between Resident #5 and Resident #8.

The CI that was submitted to the Director did not indicate that there were 3 separate incidents of resident to resident sexual abuse, and did not include the dates and times of the incidents. [s. 107. (4) 1.]

2. The CI did not indicate Resident#8 who was the recipient of the resident to resident sexual abuse, or the staff members who discovered or responded to the incidents. [s. 107. (4) 2.]

3. There was no indication Resident #8 was assessed and actions were taken to protect Resident #8 from Resident #5. [s. 107. (4) 3.] (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 07, 2013

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

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence.

Grounds / Motifs :

1. 1. The licensee was issued non-compliance (written notification and voluntary plan of correction) for S. 98 on May 22, 2013 during inspection # 2013_220111_0006, on August 12, 2013 during inspection # 2013_195166_0019 and on September 12, 2013 during inspection # 2013_195166_0028.

2. Related to log # 000467:

Clinical documentation for Resident #6 indicated a incident of suspected sexual abuse occurred between Resident #6 and Resident #10 and there was no indication the police were notified.

3. Related to log #000598:

Clinical documentation for Resident #1 indicated there were two incidents of resident to resident physical abuse that occurred: between Resident #1 and Resident #5; between Resident #1 and an unknown resident and there was no indication the police were contacted. A third incident of resident to resident physical abuse occurred between Resident #1 and Resident #2 and the police were not notified until the next day.

4. Related to log #000598:

Clinical documentation of Resident #5 indicated that there were 3 separate incidents of suspected sexual abuse that occurred between Resident #5 and Resident #8 and there was no indication the police was notified. (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 09, 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.

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

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 8th day of October, 2013

Signature of Inspector / Signature de l'inspecteur : LBrown

Name of Inspector / Nom de l'inspecteur : LYNDA BROWN

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