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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 27, 2017	2017_658178_0015	013380-17	Resident Quality Inspection

Licensee/Titulaire de permis

The Corporation of the County of Renfrew
9 INTERNATIONAL DRIVE PEMBROKE ON K8A 6W5

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

BONNECHERE MANOR
470 ALBERT STREET RENFREW ON K7V 4L5

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

SUSAN LUI (178), ANANDRAJ NATARAJAN (573), RENA BOWEN (549)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 5, 6, 10, 11, 12, 13, 16, 17, 18, 19, 2017.

The following Logs were completed as part of this inspection:
034132-16, 001070-17, and 008680-17-alleged staff to resident abuse
000404-17-alleged neglect of a resident
023474-17-alleged resident to resident abuse
034331-16 and 023015-17-injury of a resident with an unknown cause
029970-16-fall causing injury
024585-16-fall/improper transfer causing injury

During the course of the inspection, the inspector(s) spoke with Residents, Family Members, Personal Support Workers (PSWs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Food Service Workers, Housekeeping Staff, the Client/Outreach Programs Supervisor, Resident Care Coordinators (RCCs), the Environmental Services Supervisor, the Director of Care (DOC), the Director of Long-Term Care.

During the course of the inspection, the inspector(s) toured residential and non-residential areas, reviewed health care records, reviewed selected policies and procedures, observed a medication pass and observed staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

8 WN(s)
6 VPC(s)
0 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. 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for resident #017 sets out the planned care for the resident, related to responsive behaviours.

An identified critical incident report (CIR) was submitted to the Director for a resident #031 to resident #017 alleged resident to resident sexual abuse incident that occurred on an identified date.

Resident #017 was admitted with responsive behaviours and was receiving medications to manage behaviours. Resident #017's recent quarterly MDS assessment on an identified date, indicated that resident #017 had declined cognitively.

On October 18, 2017, Inspector #573 reviewed resident #017's nursing progress notes that indicated on an identified date, PSW staff observed resident #017 and resident #031 engaged in inappropriate affectionate behaviour. PSW staff immediately intervened and separated both the residents. Further nursing progress notes documentation a week later, indicated that resident #017 and resident #031 were observed again engaging in inappropriate affectionate behaviour. Staff intervened immediately and redirected the residents.

Inspector #178 interviewed RPN #114 on October 17, 2017. RPN #114 indicated that staff was aware of the inappropriate affectionate behaviour between resident #017 and resident #031. Staff had been monitoring the two residents to try to prevent this behavior and prevent it from escalating.

Inspector #178 interviewed PSW #126 on October 18, 2017. PSW #126 indicated that resident #017 and resident #031 were frequently found engaging in inappropriate behaviour. The staff was taking precautions to monitor the two residents, to stop the affectionate behavior and to ensure that they were not ever alone together.

On October 18, 2017, Inspector #573 reviewed resident #017's written plan of care in place at the time of incidents and the current care plan in place for the resident's responsive behaviours. Upon review, inspector #573 found that resident #017's care plan does not contain any specific interventions regarding how to manage the resident's inappropriate affectionate behaviours, including the need for heightened monitoring for resident #017, when displaying any inappropriate affectionate behaviours.

On October 18, 2017, Inspector #573 discussed the written plan care in place for resident #017 in the presence of home's DOC. After review, the DOC indicated to Inspector #573 that resident #017's care plan does not contain the planned care for resident #017 regarding the specific interventions to manage resident #017's inappropriate affectionate responsive behaviours. [Log #023474-17] [s. 6. (1) (a)]

2. The licensee has failed to ensure that there is a written plan of care for resident #031 that sets out the planned care for the resident with regards to responsive behaviours.

Review of resident #031's health record indicated that the resident is cognitively impaired, and requires assistance with all activities of daily living.

An identified Critical incident Report (CIR), submitted by the home on an identified date, indicated that resident #031 and resident #017, both of whom are cognitively impaired, were found alone together and inappropriately clothed. The residents were separated, and no injury was assessed.

On October 17, 2017, RPN #114 indicated to Inspector #178 that on an identified date, PSW #126 reported that she found resident #031 and resident #017 alone together and resident #031 was inappropriately clothed at the time. RPN #114 indicated that resident #031 and resident #017 had been exhibiting inappropriate affection toward each other for a couple of weeks prior to this incident. Staff on the unit had been instructed to keep the two residents apart, in an attempt to prevent the behaviour from escalating. RPN #114 also indicated that resident #031 would become agitated and aggressive with the staff on occasion. Interventions to manage this behaviour included medication as needed, removing the resident to a quiet area, and sending in a different staff member with whom

the resident may be more cooperative.

During an interview with Inspector #178 on October 18, 2017, PSW #126 indicated that on an identified date, she found resident #031 and resident #017 alone together and inappropriately clothed. No physical contact was observed between the residents at this time. PSW #126 indicated that in the days prior to this incident, the two residents would sometimes exhibit inappropriate affection toward each other, and that staff had been monitoring the two residents as a precaution, to prevent them from behaving inappropriately with each other.

Review of resident #031's progress notes indicated that the resident was exhibiting identified responsive behaviours for at least two weeks prior to being found alone and inappropriately clothed with resident #017. The progress notes indicated that over the two weeks prior to being found alone with resident #017, the two residents were observed exhibiting inappropriate affection toward each other on multiple occasions. Progress notes for resident #031 on two identified dates also document episodes of aggression towards staff. A physician communication note on an identified date, indicates that the resident appears to be more aggressive with particular staff during care.

Review of resident #031's written plan of care in place prior to being found alone and inappropriately clothed with resident #017, indicated no planned care for responsive behaviours. No written goals or interventions were present to address the resident's behaviours of inappropriate affection towards resident #017, or to address agitation and aggression towards staff during care.

On October 18, 2017, the DOC indicated to Inspector #178 that prior to the incident when resident #031 was found inappropriately clothed and alone with resident #017, there was no written plan of care for resident #031 for responsive behaviours. The DOC indicated that registered staff should have developed a written plan of care for resident #031's responsive behaviours when the resident was initially assessed to have the behaviours. [Log #023474-17] [s. 6. (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 there is a written plan of care for resident #017 and resident #031 that sets out the planned care for each resident with regards to responsive behaviours, to be implemented voluntarily.

WN #2: 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. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The licensee's Prevention of Resident Abuse or Neglect policy# G-006 last review date October 16, 2017, page three, bullet number two, indicated the following: Anyone who witnesses any form of abuse/neglect/inappropriate care or is aware of alleged or suspected abuse/neglect/inappropriate care is responsible for reporting it to their supervisor or designate immediately.

An identified critical incident report was submitted on an identified date, to the Director for an alleged staff to resident abuse.

On an identified date, while providing care to resident #026, PSW #110 witnessed PSW #111 yell at resident #026 with inappropriate and threatening comments. On the same day, PSW #110 discussed the incident offsite with PSW #112 who was not working on the day of the incident. The following day, PSW #112 reported the alleged staff to resident verbal abuse incident that occurred the previous day, to the RPN #114 at which

time the information was brought to the unit in charge RN and Resident Care Coordinator (RCC) #115's attention. The day after PSW #112 reported the incident, an internal investigation was initiated that later confirmed verbal abuse occurred and disciplinary action was taken against PSW #111.

On October 13, 2017, Inspector #573 reviewed the home's PSW staff schedule which indicated that PSW #111 continued to work on the same unit on the evening of the incident and the following evening as well.

On October 13, 2017, during an interview, RCC #115, indicated to Inspector #573 that the verbal abuse incident should have been reported by PSW #110 immediately to the unit RN in charge or member of the management team who was working at that time, as per the home's policy to promote zero tolerance of abuse and neglect. [Log #034132-16] [s. 20. (1)]

2. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

The licensee's Prevention of Resident Abuse or Neglect policy# G-006 last review date October 16, 2017, page three, bullet number two, indicated the following: Anyone who witnesses any form of abuse/neglect/inappropriate care or is aware of alleged or suspected abuse/neglect/inappropriate care is responsible for reporting it to their supervisor or designate immediately.

The licensee submitted a Critical Incident Report (CIR) on an identified date, indicating that PSW #122 reported on an identified date, in a telephone voice message to the Director of Care (DOC) that PSW #123 knowingly neglected to provide specified care to resident #023 during a night shift, as the PSW was too busy and didn't want to wake the resident.

During an interview with the DOC on October 16, 2017 it was indicated to Inspector #549 that the DOC was away from the home at the time the voice message was left by PSW #123, and the DOC returned to the home a week later. The DOC indicated to the inspector that her voice message clearly indicated the dates that the DOC would be absent from the home. The DOC indicated that upon her returning to the home, she was notified of the allegation of neglect of resident #023 when she checked her telephone voice messages.

During a telephone interview on October 17, 2017 with PSW #122 it was indicated to Inspector #549 that she left the telephone voice message on the DOC's telephone "in the heat of the moment". PSW #122 indicated to the inspector that she should have reported the allegation of neglect of resident #023 to the Registered Practical Nurse on the unit at the time of the incident.

The licensee failed to ensure that PSW #122 complied with the licensee's Prevention of Resident Abuse or Neglect policy #G-006 when the PSW did not report to her supervisor or designate immediately related to the allegation of neglect of resident #023. [Log #000404-17] [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 that the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: 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. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported, is immediately investigated.

An identified Critical incident Report (CIR), submitted by the home on an identified date, indicated that resident #031 and resident #017, both of whom are cognitively impaired, were found alone together and both were inappropriately clothed. The residents were separated, and no injury was assessed.

Review of the health records for resident #017 and resident #031 indicated that both residents are cognitively impaired, and wander on the unit.

During an interview with Inspector #178 on October 18, 2017, PSW #126 indicated that on an identified date, she observed resident #031 and resident #017 alone together and inappropriately clothed. No physical contact was observed between the residents. PSW #126 separated the residents and immediately reported the incident to the RPN in charge of the unit for that shift.

During an interview with Inspector #178 on October 17, 2017, RPN #114 indicated that on an identified date, PSW #126 reported to him that she had found resident #017 and resident #031 alone together and resident #031 was inappropriately clothed. RPN #114 indicated that the residents were separated, and he assessed them for any signs of distress, and found none. RPN #114 indicated that neither resident was assessed physically. RPN #114 indicated that both residents are cognitively impaired, and would be unable to consent to sexual activity. RPN #114 reported the incident to RN #125, who was in charge of the home on that shift.

During an interview with Inspector #178 on October 17, 2017, RN #125 indicated that on an identified date, RPN #114 reported to her that resident #017 and resident #031 were found alone together, the residents were not distressed, and RPN #114 may have stated something about the residents being inappropriately clothed, although RN #125 was unsure about this fact. RN #125 indicated that she did not investigate the incident, and did not report it to the manager on call or the DOC because the residents were not distressed, no physical contact was witnessed, and the staff was unsure what had transpired. RN #125 described the report of the incident from RPN #114 as vague. RN #125 indicated that neither resident #017, nor resident #031 would be capable of consenting to sexual activity.

During an interview with Inspector #178 on October 19, 2017, the DOC indicated that she was made aware of the incident between resident #017 and resident #031, the morning after it occurred, during high risk rounds. The DOC indicated that the incident should have been immediately investigated by the RN in charge, and that this was not done. [Log #023474-17] [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 abuse of a resident by anyone, that the licensee knows of, or that is reported, is immediately investigated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone has occurred, immediately reported the suspicion and the information upon which it was based to the Director under the Long-

Term Care Homes Act (LTCHA).

An identified Critical incident Report (CIR) submitted by the home, indicated that on an identified date, resident #031 and resident #017, both of whom are cognitively impaired, were found alone together, and inappropriately clothed. The residents were separated, and no injury was assessed.

Review of the health records for resident #017 and resident #031 indicated that both residents are cognitively impaired and wander on the unit.

During an interview with Inspector #178 on October 18, 2017, PSW #126 indicated that on an identified date, she observed resident #017 and resident #031 alone together, and inappropriately clothed. No physical contact was observed between the residents. PSW #126 separated the residents and immediately reported the incident to the RPN in charge of the unit for that shift.

During an interview with Inspector #178 on October 17, 2017, RPN #114 indicated that on an identified date, PSW #126 reported to him that she had found resident #017 and resident #031 alone together and resident #031 was inappropriately clothed. RPN #114 indicated that the residents were separated, and he assessed them for any signs of distress, and found none. RPN #114 indicated that neither resident was assessed physically. RPN #114 indicated that both residents are cognitively impaired, and would be unable to consent to sexual activity. RPN #114 reported the incident to RN #125, who was in charge of the home on that shift.

During an interview with Inspector #178 on October 17, 2017, RN #125 indicated that on an identified date, RPN #114 reported to her that resident #017 and resident #031 were found alone together, the residents were not distressed, and RPN #114 may have stated something about the residents being inappropriately clothed, although RN #125 was unsure about this fact. RN #125 indicated that she did not investigate the incident, and did not report it to the manager on call or the DOC because the residents were not distressed, no physical contact was witnessed, and the staff was unsure what had transpired. RN #125 described the report of the incident from RPN #114 as vague. RN #125 indicated that neither resident #017, nor resident #031 would be capable of consenting to sexual activity.

During an interview with Inspector #178 on October 19, 2017, the DOC indicated that she was made aware of the incident between resident #017 and resident #031 during high

risk rounds on the morning after it occurred, and she reported the incident to the Ministry of Health and Long-Term Care (MOHLTC) shortly thereafter. The DOC indicated that the incident should have been immediately investigated and reported to management on call and the MOHLTC by the RN in charge on the shift that it occurred. [Log #023474-17] [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 the person who had reasonable grounds to suspect that abuse of a resident by anyone has occurred, immediately reported the suspicion and the information upon which it was based to the Director under the LTCHA, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

An identified Critical Incident Report, submitted by the licensee on an identified date, indicated that resident #029 was lowered to the floor during a transfer in the tub room. The resident was assessed by registered staff and found to not be injured as a result of the incident. Four days later, the resident was found to have difficulty with weight-bearing. The resident was reassessed and found to have bruising on a specific body part.

During an interview with Inspector #178 on October 12, 2017, the DOC indicated that the home investigated the incident, including conducting interviews with multiple staff members. The investigation resulted in disciplinary action being was taken against PSW #116 and PSW #121 for failing to follow the home's Zero Lift Policy and failure to follow the resident's Care Plan.

During an interview on October 16, 2017, PSW #116 indicated to Inspector #178 that on an identified date, she transferred resident #029 unsafely by attempting to transfer the resident from the wheelchair to the tub chair while alone, before PSW #121 was present to assist her, even though the resident's plan of care stated that he/she required two staff members to assist the resident to transfer. As a result, when the resident became unable or to stand, PSW #116 was unable to get the resident safely onto the tub chair in time, and had to lower the resident to the ground.

Review of the home's investigation into the incident indicated that disciplinary action was taken against PSW #116 and PSW #121 for failing to follow the home's Zero Lift Policy, failure to follow the resident's Care Plan, and for violation of Resident's Rights.
[Log #024585-16] [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have received retraining annually relating to the home's policy to promote zero tolerance of abuse and neglect of residents.

During an interview with Inspector #178 on October 18, 2017, the DOC indicated that RPN #114 did not receive retraining annually on the home's policy to promote zero tolerance of abuse and neglect of residents. The DOC indicated that RPN #114 most recently re-trained on the home's policy to promote zero tolerance of abuse and neglect of residents in March 2013. The DOC indicated that RPN #114 did not receive retraining in the home's policy to promote zero tolerance of abuse and neglect of residents in 2014, 2015 or 2016. The DOC also indicated that in 2016, only 53% of staff completed retraining in the home's policy to promote zero tolerance of abuse and neglect of residents. The DOC supplied staff training records which support the information provided during the interview with Inspector #178. The DOC indicated that the home now requires staff to complete their mandatory training by October 31 each year, and those who have not done so will be contacted by their manager to ensure that all training is completed before the end of the year. The DOC indicated that as of October 18, 2017, more than eighty percent of staff had completed their mandatory training for 2017. [Log #023474-17] [s. 76. (4)]

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 staff have received retraining annually relating to the home's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents.

On October 5, 2017, it was observed by Inspector #178 on the second level of the home, what appeared to be a staff kitchen in room #2120. This kitchen contained a kettle, coffee maker, toaster, and two fridges. There was no door present on this room, and nothing to prevent entry from the hallway. The doors between the Henry Murdoch Two home area and the hallway leading to the staff kitchen were closed but not locked. No staff was present in the kitchen, but staff was present in the hallway area nearby. No residents were present in the kitchen or the hallway leading to the kitchen.

On October 11, 2017, Inspector #178 toured the area around the staff kitchen with the home's Director of Long-Term Care. The Director of Long-Term Care indicated that room #2120 is a staff kitchen, not a resident home area, and that the door to the kitchen had been recently removed in order to fit a new fridge which was recently installed. The Director indicated that the doors leading to the kitchen hallway from the Henry Murdoch Two resident home area are kept closed but not locked, and therefore a resident could access the hallway leading to the staff kitchen. The Director indicated that the door to kitchen, room #2120, would be replaced promptly.

On October 13, 2017, the home's Director of Long Term Care indicated to Inspector #178 that a door with a lock had been installed on the staff kitchen on the second floor. On October 13, 2017, Inspector #178 observed that a door with a lock had been added to the staff kitchen room #2120. The door to the kitchen was open at the time, and staff was present in the kitchen and in the hallway area surrounding the kitchen. [s. 9. (1) 2.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

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).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #23's Substitute Decision Maker (SDM) was notified within 12 hours upon becoming aware of any other alleged suspected or witnessed incident of abuse or neglect of resident #023.

The licensee submitted a Critical Incident Report (CIR) on an identified date, indicating that PSW #122 reported on an identified date in a telephone voice message to the Director of Care (DOC), that PSW #123 knowingly neglected to provide specified care to resident #023 during a night shift as the PSW was too busy and didn't want to wake the resident.

During an interview with RPN #103 on October 16, 2017, it was indicated to Inspector #549 that resident #023 has a delegated substitute decision maker (SDM) who staff notified when there is a change in the resident's condition or any incident that occurs involving the resident.

Inspector #549 reviewed resident #023's progress notes between the date of the alleged neglect and ten days subsequent to that date. The inspector was unable to locate any documentation indicating that the resident's SDM was notified of the allegation of neglect

of the resident.

During an interview with the DOC on October 16, 2017, it was indicated to Inspector #549 that resident #023's SDM was not contacted when the licensee became aware of the allegation of neglect of resident #023. The DOC indicated to Inspector #549 that she is not sure why the SDM was not contacted as it is the licensee's usual practice to do so. [Log #000404-17] [s. 97. (1) (b)]

2. The licensee failed to ensure that resident #023's SDM was immediately notified of the results of the investigation of the alleged neglect of resident #023.

The licensee submitted a Critical Incident Report (CIR) on an identified date, indicating that PSW #122 reported on an identified date in a telephone voice message to the Director of Care (DOC), that PSW #123 knowingly neglected to provide specified care to resident #023 during a night shift as the PSW was too busy and didn't want to wake the resident.

The DOC indicated during an interview on October 16, 2017, with Inspector #549 that the licensee became aware of the allegation of neglect a week after PSW #122 left the voice message, when the DOC returned to work and retrieved her messages. During the same interview with the DOC it was indicated that an investigation related to the allegation of neglect of resident #023 was initiated immediately. The DOC also indicated that the investigation results failed to verify that neglect of resident #023 had occurred.

Inspector #549 reviewed the licensee's investigation documentation related to the allegation of neglect of resident #023. The inspector was unable to locate any documentation indicating that the SDM was notified of the outcome of the alleged neglect investigation.

On October 16, 2017 during an interview, the DOC indicated to Inspector #549 that the investigation was completed on an identified date and that the licensee failed to notify resident #023's SDM of the outcome of the alleged neglect investigation. [Log #000404-17] [s. 97. (2)]

Issued on this 27th day of October, 2017

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

Original report signed by the inspector.