Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

# Inspection Report under the Long-Term Care Homes Act, 2007

# Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée


**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

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## Amended Public Copy/Copie modifiée du rapport public

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log #/ No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jul 08, 2020 | 2020_617148_0007 (A1) | 002071-20, 002329-20, 003959-20 | Critical Incident System |

### Licensee/Titulaire de permis

The Glebe Centre Incorporated
950 Bank Street OTTAWA ON K1S 5G6

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

Glebe Centre
950 Bank Street OTTAWA ON K1S 5G6

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

Amended by AMANDA NIXON (148) - (A1)

## Amended Inspection Summary/Résumé de l'inspection modifié

**Due to the current emergency orders in place amid the coronavirus pandemic, the compliance due date will be extended to October 31, 2020.**

**Issued on this 8 th day of July, 2020 (A1)**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

# Inspection Report under *the Long-Term Care Homes Act, 2007*

# Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée


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

Amended by AMANDA NIXON (148) - (A1)

## Amended 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): March 3-6 and 9-12, 2020**

**This inspection included two critical incident reports (CIR): CIR #2811-000004-20 (Log 002071-20) related to resident to resident alleged sexual abuse; and CIR #2811-000005-20 (Log 002329-20) related to staff to resident alleged verbal abuse.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Manager of Nursing Care Operations, Director of Quality Management, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Social Workers (SW), Personal Support Worker Supervisor, residents and families.**

**In addition, the Inspector(s) reviewed resident health care records, observed resident care and the resident's care environment. In addition, documents related to the prevention of abuse program, staff training records along with documents of complaints and concerns were reviewed.**

**The following Inspection Protocols were used during this inspection:**

**Critical Incident Response**
**Prevention of Abuse, Neglect and Retaliation**

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

**6 WN(s)**
**1 VPC(s)**
**1 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.)<br><br>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 :**

The licensee has failed to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

In accordance with O. Regulation 79/10, s. 2, emotional abuse means, any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident; and verbal abuse means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident. In accordance with O. Regulation 79/10, s. 5, neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

1)On a specified date, SW #111 observed interactions between PSW #118 and resident #003. SW #111 reported that the interactions included PSW #118 loudly speaking to the resident; using physical gestures to rush the resident; using assertive and forceful language to direct the resident during care. SW #111 describes hearing the resident cry after comments were made by the PSW. SW #111 provided a written statement of events to the DOC on the same date as the occurrence. The DOC made a mandatory report to the Director and began an investigation into the incident. The DOC describes that the investigation included the following actions:
- Interview conducted with SW #111;
- Interview conducted with resident #003;
- Interview with PSW #118;
- Interview with RPN #110;
- Discussion with resident #003's substituted decision maker (SDM); and
- Collaboration with Human Resources and Manager of Nursing Operations for any historical data related to the care and services of PSW #118.

During the time of the investigation PSW #118 was removed from resident #003's care. As reported by the DOC, the DOC had understood from the interview with PSW #118 and the SDM, that the resident was known to be weepy/teary at times and may require assertive direction. The DOC concluded that no abuse had

occurred.

The Inspector spoke with PSW #113, PSW #114, RPN #110 and RPN #119. Staff described that the resident can become weepy. The resident can be confused regarding the whereabouts of the resident's family and this can cause sadness. Staff indicated however, that the resident can be easily redirected when feelings are acknowledged and the resident is engaged in other topics of discussion. Staff reported that the resident requires toileting frequently during the day and that this can cause the resident to be frustrated. Staff indicated that calm and supportive approaches work best. Staff denied the need for assertive direction to complete care.

The Inspector spoke with SW #111 regarding the observations made on February 6, 2020. SW #111 was aware that the resident can become tearful. SW #111 described that resident #003 can not always articulate why the resident is sad due to the resident's cognitive status. When asked, SW #111 described that the crying by resident #003 on February 6, 2020, was different than the tearfulness sometimes exhibited. SW #111 described that the resident was crying and that the crying appeared to be a reaction in response to PSW #118's actions.

The plan of care for resident #003 described that the resident can become tearful related to feelings of sadness. In review of the Point of Care Tasks, there was no documentation to support that the resident had exhibited tearfulness during a time period surrounding the observations of SW #111. The plan of care and most recent Minimum Data Set Assessment did not indicate any responsive behaviours, including resisting care, nor were there directions to support the resident requires assertive direction in care.

Inspector #148 discussed the findings of the interviews conducted during this inspection with the DOC. Upon review of the information collected during this inspection, the DOC was asked how the information reflected on the incident, to which the DOC indicated that the incident was more alarming than first perceived.

The licensee's investigation did not seek out information pertinent to the understanding of the events observed by SW #111. The licensee concluded that no abuse had occurred without a completed set of information to support this conclusion.

In review of the policy to promote zero tolerance of abuse and neglect, identified

as policy #RC 4.00.00, titled Resident Abuse and Neglect: Zero Tolerance, the investigation was described to be conducted by the nurse receiving the report of abuse and/or neglect. The policy describes that the nurse is to conduct the investigation using a checklist. In discussion with RPN #110 and RPN #119, along with the Manager of Nursing Care Operations, the aforementioned checklist could not be identified. In discussion with both the DOC and Manager of Nursing Care Operations, it is expected that the nurse on the floor would conduct initial information gathering, however the licensee's investigation would be conducted by either the DOC or the Manager of Nursing Care Operations. The policy to promote zero tolerance of abuse and neglect identifies that the DOC or designate cooperates with external investigations, informs the Executive Director of developments as warranted and maintains confidentiality.

2) As indicated by the CIR, the licensee's investigation revealed that SW #112 had made a report to RPN #110 regarding the interaction between PSW #118 and resident #003, approximately one week prior to incident observed by SW #111.

The DOC was unable to articulate what had been reported to RPN #110, by SW #112; the DOC had not interviewed SW #112 regarding the report. The DOC understood that the report was related to similar issues, whereby PSW #118 was rough/assertive with words used towards resident #003.

The Inspector spoke with SW #112, who indicated that approximately one week prior to the incident observed by SW #111, SW #112 had overheard a PSW providing direction to resident #003 with a tone of voice that was not appropriate, louder than usual and the comments were direct, disrespectful and curt. SW #112 indicated that the observations were reported to RPN #110, and at that time the PSW was identified as PSW #118.

The Inspector spoke with RPN #110 who confirmed the report received from SW #112. In review of the report received, RPN #110 identified the interaction between PSW #118 and resident #003 to be suspected abuse. The RPN indicated that the RPN had a conversation with PSW #118, whereby PSW #118 apologized for any wrong doing but denied remembering saying the words as reported by SW #112. No further actions were taken by either SW #112 or RPN #110 to protect resident #003. The incident was not reported to the home's senior management until the initiation of this inspection.

As indicated by WN #2, related to LTCHA, 2007, s.24, the Director was not immediately informed of the suspected abuse, that was observed by SW #112, until the initiation of this inspection.

As further indicated by WN #2, incidents were identified of alleged staff to resident abuse and neglect that the management staff responsible to review these incidents did not identify the incidents as alleged abuse and/or neglect, and therefore, these incidents were not reported to the Director until the initiation of this inspection.

3) At the conclusion of the licensee's investigation, PSW #118 was assigned to complete three online learning courses, with one identified to be related to abuse. The DOC had reported that these courses were assigned to PSW #118 as there was a power imbalance with the approached used by PSW #118. The DOC noted that some of the words used by the PSW along with other gestures were not all required to complete the resident's care.

As of March 10, 2020, PSW #118 had yet to complete these assigned courses.

As indicated by WN #5, related to O. Regulation 79/10, s.216, PSW #122 was reported in early 2020, by a co-worker for suspected verbal and emotional abuse. PSW #122 was also involved in an incident of alleged physical abuse in Inspection Report (#2019_617148_0029) issued November 1, 2019. The concern form reviewed indicated that PSW #122 was to complete assigned online learning related to recent concerns. The concern form noted that these courses had yet to be completed.

As indicated by WN #5, related to O. Regulation 79/10, s.216, PSW #104, PSW #118, SW #112, PSW #122 and PSW #125, have not been provided training on the licensee's policy to promote zero tolerance of abuse and neglect of residents.

The licensee has failed to protect residents from abuse and neglect in that training has not been completed as required by the LTCHA, 2007. In addition, when staff are identified as requiring further training, due to involvement in incidents of alleged abuse or neglect, the licensee has failed to ensure that this training is completed.

4) As indicated by WN #4, related to O. Regulation 79/10, s. 99, the licensee has failed to ensure that an evaluation was made to determine effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents.

(#148, Log 002329-20)

***Additional Required Actions:***

**CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

**(A1)**
**The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001**

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**WN #2: 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. (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 :**

The licensee has failed to ensure that resident #003's substitute decision-maker (SDM) was notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

As described in WN #1, related to LTCHA 2007, s. 19, SW #111 observed PSW #118 to converse with resident #003 in a manner that was suspect of verbal abuse, on a specified date.

The DOC conducted an investigation which concluded on a specified date. In an interview with the DOC, it was reported that the SDM was not yet informed of the results of that investigation.

(#148, Log 002329-20)

***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 resident or resident's substitute decision-maker is notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation, to be implemented voluntarily.***

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**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 :**

The licensee has failed to ensure that the policy that promotes zero tolerance of abuse was complied with.

The licensee's policy was identified as “Resident Abuse and Neglect: Zero Tolerance”, policy number RC 4.00.00, revised December 2019.

The policy requires that the nurse receiving a report of alleged abuse or neglect to “notify the MOHLTC if the alleged, suspected or witnessed or un-witnessed incident of abuse or neglect of a resident meets the criteria for Ministry notification. The decision about whether to submit a report on an alleged incident of abuse or neglect will depend upon whether the circumstances of the alleged abuse or neglect meet the definitions of abuse in LTCHA Section 2(1) (Appendix A).”

An incident of alleged sexual abuse occurred on a specified date. RPN #104 documented that resident #001 was observed to be interacting with resident #002 in a sexual nature.

In an interview held with RPN #104, the RPN indicated that they contacted the Manager of Nursing Care Operation on the following day. The RPN was informed by the Manager of Nursing Care Operations that it was a reportable incident and that it should have been reported immediately. During the interview, RPN #104 indicated that they were not aware of all the home's policies nor were they aware of all the requirements of those policies.

RPN #104 failed to comply with the policy to promote zero tolerance of abuse and neglect of residents.

(#126, Log #000275-20, 002071-20)

**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 :**

The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

1) In accordance with O. Regulation 79/10, s. 2, emotional abuse means, any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident; and verbal abuse means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident. In accordance with O. Regulation 79/10, s. 5, neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health,

safety or well-being of one or more residents.

As described in WN #1, related to LTCHA 2007, s. 19, SW #111 observed PSW #118 to converse with resident #003 in a manner that was suspect of verbal abuse, on a specified date. During the inspection into this incident it was reported by RPN #110 and SW #112, that a previous incident of alleged verbal abuse had occurred one week earlier. This previous incident was not reported to the Director until the initiation of this inspection. RPN #110 reported to the Inspector that the RPN had understood that it was the responsibility of the management team to make such reports to the Director. As indicated in WN #1 neither RPN #110 nor SW #112 reported the incident to a member of the management team.

In an interview with the Director of Quality Management regarding the evaluation of the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect, it was reported that the home tracks all complaints and concerns. The Director of Quality Management reported that in 2019 there were concerns brought forward related to communication and staff behaviour. The files maintained for concerns and complaints were reviewed by Inspector #148 and #126. The following were identified:

On a specified date – a family member of resident #004 indicated that resident #004 had been having ongoing problems with two PSW staff members, including comments made to resident #004 that were inappropriate whereby the resident felt ashamed. Other claims made by the family member included that staff are rough and inconsiderate, pushing the resident to do what the resident cannot do. The the family member reported this causes anxiety for the resident.

On a specified date – Resident #005 reported that PSW #120 made comments about the resident's physical appearance. The resident reported feeling upset, intimidated and anxious by the comments made. The concern from indicated that PSW #120 was provided with coaching, including an online learning course titled, Power Imbalances and Resident abuse.

On a specified date – Resident #006 reported that PSW #121 was very unpleasant. Resident reported having called for assistance, the staff member did not provide that assistance and the resident waited at least 45 minutes for assistance to be given by another PSW. On a subsequent date, the same resident reported that PSW #121 creates an atmosphere that is upsetting, insulting and unpleasant. In addition, the resident reported that the PSW does not respond to

the call bell. The concern from indicated that coaching was provided to PSW #121, including a one to one session on subtle abuse.

On a specified date – PSW #123 reported that PSW #122 screams in the hallways, starts arguments with residents, does not greet residents, and removes resident's clothing fast and without talking to the resident.

These identified incidents were reviewed by staff members including DOC #124 and the Manager of Nursing Care Operation, under the home's process for complaints and concerns. The incidents of alleged abuse and neglect, as listed above, were not reported to the Director.

(#148, Log 002329-20)

2) A CIR was submitted to the Director on a specified date related to an allegation of sexual abuse that occurred on the day prior.

The incident occurred on the evening of January 2, 2020. RPN #104 documented that resident #001 was observed to interact with resident #002 in a sexual nature. Neither residents could explained to the attending PSW, what they were doing.

In an interview held with RPN #104, the RPN indicated that they contacted the Manager of Nursing Care Operations the after the incident and was informed by the Manager of Nursing Care Operations that it was a reportable incident and that it should have been reported immediately.

In an interview with the Manager of Nursing Care Operations, it was reported that they became aware of the incident of alleged sexual abuse, one day after the occurrence of the incident, when they overheard RPN #104 talking about the incident. At that time, PRN #104 was informed that the incident should have been immediately reported.

The licensee failed to ensure that the Director was immediately notified of an allegation of sexual abuse.
(#126, Log #000275-20, 002071-20)

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,**
**(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;**
**(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;**
**(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;**
**(d) that the changes and improvements under clause (b) are promptly implemented; and**
**(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.**

**Findings/Faits saillants :**

The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences.

During an interview with the Director of Quality Management it was reported that no formal review has been undertaken to evaluate the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents.

The Inspector spoke with the Manager of Nursing Operations and the Executive Director whereby no such evaluation was identified as being completed in the last calendar year.

As indicated by the home's compliance history of 2019, the licensee has had previous issuance of section 20 of the LTCHA, 2007:
- March 5, 2019 (Inspection #2019_617148_0029) which noted that the policy to promote zero tolerance of abuse and neglect was not complied with; and
- November 5, 2019 (Inspection #2019_761733_0001) which noted deficiencies in the content of the policy to promote zero tolerance of abuse and neglect.

As described by WN #1, the policy to promote zero tolerance of abuse and neglect of residents, does not reflect current practices in the home, specific to the directions outlined for the licensee's investigation into reported incidents of abuse and neglect.

(#148, Log 002329-20)

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 216. Training and orientation program**

**Specifically failed to comply with the following:**

**s. 216. (1) Every licensee of a long-term care home shall ensure that a training and orientation program for the home is developed and implemented to provide the training and orientation required under sections 76 and 77 of the Act. O. Reg. 79/10, s. 216 (1).**

**Findings/Faits saillants :**

The licensee has failed to ensure that persons who have received training under section 76(2) receive retraining in the long-term care home's policy to promote zero tolerance of abuse and neglect of residents annually.

In accordance with LTCHA 2007, s.76 and O. Regulation 79/10, s.219, all staff at the home are to receive training in the long-term care home's policy to promote zero tolerance of abuse and neglect prior to performing their responsibilities and annually thereafter.

The home's policy to promote zero tolerance of abuse and neglect of residents was identified as the Resident Abuse and Neglect: Zero Tolerance, #RC 4.00.00, dated December 2019.

During the course of this inspection the training records of PSW #104, RPN #110, PSW #118, SW #112, PSW #122 and PSW #125, were reviewed and discussed with the Director of Quality Management. It was determined that PSW #104, PSW #118, SW #112, PSW #122 and PSW #125 had not been provided with training on the policy to promote zero tolerance of abuse and neglect. The Director of Quality Management noted that all registered nursing staff were provided with the policy after the update in December 2019. It was reported that the policy was distributed and changes discussed at the regular nursing meetings to which registered nursing staff attend. As indicated by WN #2, related to LTCHA 2007, s. 24, RPN #110 did not report alleged abuse immediately to the Director and the RPN understood that management staff were to make this report.

PSW #122 and #125 were identified in an inspection report issued November 2019 (#2019_617148_0029), whereby the staff members were involved in an incident of alleged abuse. The report identified that PSW #122 had not received annual training on the policy to promote zero tolerance of abuse and neglect; and that training of PSW #125 did not include training on the relationship between

power imbalances between staff and residents and situations that may lead to abuse and neglect. In review of the training records available March 10, 2020, PSW #122 and PSW #125 had not been provided with training on the policy to promote zero tolerance of abuse and neglect. As of March 10, 2020, PSW #125 had not been provided with training on the relationship between power imbalances between staff and residents and situations that may lead to abuse and neglect.

In a discussion with the Director of Quality Management it was reported that the home has developed a plan to provide various training related to abuse and neglect over the course of the next year. Training related to topics of abuse and neglect and the policy to promote zero tolerance of abuse and neglect were planned to be completed by September 2020.

The licensee did not ensure that all staff of the home have received training in the long-term care home's policy to promote zero tolerance of abuse and neglect.

(#148, Log 002329-20)

**Issued on this 8 th day of July, 2020 (A1)**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

## Amended Public Copy/Copie modifiée du rapport public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | Amended by AMANDA NIXON (148) - (A1) |
| **Inspection No. / No de l'inspection :** | 2020_617148_0007 (A1) |
| **Appeal/Dir# / Appel/Dir#:** | |
| **Log No. / No de registre :** | 002071-20, 002329-20, 003959-20 (A1) |
| **Type of Inspection / Genre d'inspection :** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Jul 08, 2020(A1) |
| **Licensee / Titulaire de permis :** | The Glebe Centre Incorporated<br>950 Bank Street, OTTAWA, ON, K1S-5G6 |
| **LTC Home / Foyer de SLD :** | Glebe Centre<br>950 Bank Street, OTTAWA, ON, K1S-5G6 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Lawrence Grant |

To The Glebe Centre Incorporated, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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**Order # / No d'ordre:** 001

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 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 :**

## Order(s) of the Inspector

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

## Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

The licensee must be compliant with LTCHA , 2007, s.19(1)

Specifically the licensee must:

1) Ensure that all staff at the home receive training in the long-term care home’s policy to promote zero tolerance of abuse and neglect of residents. Training shall include, at minimum, the contents of LTCHA 2007, s.20(2) and O. Regulation s.96;
a) Ensure that all staff at the home receive training, as outlined by the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care and situations that may lead to abuse and neglect and how to avoid such situations;
b) Ensure that staff responsible for the review of complaints and concerns are trained
in the definitions of abuse and neglect and the recognition of incidents that require immediate report to the Director; and
c) Maintain a record of all training provided to staff, including the contents of the training and staff attendance.

2) Develop and implement an evaluation to determine the effectiveness of the licensee’s policy to promote zero tolerance of abuse and neglect of residents and what changes and improvements are required to prevent further occurrences;
a) The evaluation is to consider the analysis of every incident of abuse or neglect of a resident that the licensee is aware of;
b) Changes and improvements identified are promptly implemented; and
c) A written record shall be maintained of the evaluation, including analysis, changes and improvements identified, the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented.

3) Review and revise the policy to promote zero tolerance of abuse and neglect to ensure that the policy provides for the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation.

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## Ordre(s) de l'inspecteur

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**Grounds / Motifs :**

1. The licensee has failed to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

In accordance with O. Regulation 79/10, s. 2, emotional abuse means, any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident; and verbal abuse means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident. In accordance with O. Regulation 79/10, s. 5, neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

1)On a specified date, SW #111 observed interactions between PSW #118 and resident #003. SW #111 reported that the interactions included PSW #118 loudly speaking to the resident; using physical gestures to rush the resident; using assertive and forceful language to direct the resident during care. SW #111 describes hearing the resident cry after comments were made by the PSW.
SW #111 provided a written statement of events to the DOC on the same date as the occurrence. The DOC made a mandatory report to the Director and began an investigation into the incident. The DOC describes that the investigation included the following actions:
- Interview conducted with SW #111;
- Interview conducted with resident #003;
- Interview with PSW #118;
- Interview with RPN #110;
- Discussion with resident #003's substituted decision maker (SDM); and
- Collaboration with Human Resources and Manager of Nursing Operations for any historical data related to the care and services of PSW #118.

During the time of the investigation PSW #118 was removed from resident #003's care. As reported by the DOC, the DOC had understood from the interview with PSW #118 and the SDM, that the resident was known to be weepy/teary at times and may require assertive direction. The DOC concluded that no abuse had occurred.

The Inspector spoke with PSW #113, PSW #114, RPN #110 and RPN #119. Staff described that the resident can become weepy. The resident can be confused regarding the whereabouts of the resident's family and this can cause sadness. Staff indicated however, that the resident can be easily redirected when feelings are acknowledged and the resident is engaged in other topics of discussion. Staff reported that the resident requires toileting frequently during the day and that this can cause the resident to be frustrated. Staff indicated that calm and supportive approaches work best. Staff denied the need for assertive direction to complete care.

The Inspector spoke with SW #111 regarding the observations made on February 6, 2020. SW #111 was aware that the resident can become tearful. SW #111 described that resident #003 can not always articulate why the resident is sad due to the resident's cognitive status. When asked, SW #111 described that the crying by resident #003 on February 6, 2020, was different than the tearfulness sometimes exhibited. SW #111 described that the resident was crying and that the crying appeared to be a reaction in response to PSW #118's actions.

The plan of care for resident #003 described that the resident can become tearful related to feelings of sadness. In review of the Point of Care Tasks, there was no documentation to support that the resident had exhibited tearfulness during a time period surrounding the observations of SW #111. The plan of care and most recent Minimum Data Set Assessment did not indicate any responsive behaviours, including resisting care, nor were there directions to support the resident requires assertive direction in care.

Inspector #148 discussed the findings of the interviews conducted during this inspection with the DOC. Upon review of the information collected during this inspection, the DOC was asked how the information reflected on the incident, to which the DOC indicated that the incident was more alarming than first perceived.

The licensee's investigation did not seek out information pertinent to the understanding of the events observed by SW #111. The licensee concluded that no abuse had occurred without a completed set of information to support this conclusion.

In review of the policy to promote zero tolerance of abuse and neglect, identified as policy #RC 4.00.00, titled Resident Abuse and Neglect: Zero Tolerance, the investigation was described to be conducted by the nurse receiving the report of abuse and/or neglect. The policy describes that the nurse is to conduct the investigation using a checklist. In discussion with RPN #110 and RPN #119, along with the Manager of Nursing Care Operations, the aforementioned checklist could not be identified. In discussion with both the DOC and Manager of Nursing Care Operations, it is expected that the nurse on the floor would conduct initial information gathering, however the licensee's investigation would be conducted by either the DOC or the Manager of Nursing Care Operations. The policy to promote zero tolerance of abuse and neglect identifies that the DOC or designate cooperates with external investigations, informs the Executive Director of developments as warranted and maintains confidentiality.

2) As indicated by the CIR, the licensee's investigation revealed that SW #112 had made a report to RPN #110 regarding the interaction between PSW #118 and resident #003, approximately one week prior to incident observed by SW #111.

The DOC was unable to articulate what had been reported to RPN #110, by SW #112; the DOC had not interviewed SW #112 regarding the report. The DOC understood that the report was related to similar issues, whereby PSW #118 was rough/assertive with words used towards resident #003.

The Inspector spoke with SW #112, who indicated that approximately one week prior to the incident observed by SW #111, SW #112 had overheard a PSW providing direction to resident #003 with a tone of voice that was not appropriate, louder than usual and the comments were direct, disrespectful and curt. SW #112 indicated that the observations were reported to RPN #110, and at that time the PSW was identified as PSW #118.

The Inspector spoke with RPN #110 who confirmed the report received from SW #112. In review of the report received, RPN #110 identified the interaction between PSW #118 and resident #003 to be suspected abuse. The RPN indicated that the RPN had a conversation with PSW #118, whereby PSW #118 apologized for any wrong doing but denied remembering saying the words as reported by SW #112. No

further actions were taken by either SW #112 or RPN #110 to protect resident #003. The incident was not reported to the home's senior management until the initiation of this inspection.

As indicated by WN #2, related to LTCHA, 2007, s.24, the Director was not immediately informed of the suspected abuse, that was observed by SW #112, until the initiation of this inspection.

As further indicated by WN #2, incidents were identified of alleged staff to resident abuse and neglect that the management staff responsible to review these incidents did not identify the incidents as alleged abuse and/or neglect, and therefore, these incidents were not reported to the Director until the initiation of this inspection.

3) At the conclusion of the licensee's investigation, PSW #118 was assigned to complete three online learning courses, with one identified to be related to abuse. The DOC had reported that these courses were assigned to PSW #118 as there was a power imbalance with the approached used by PSW #118. The DOC noted that some of the words used by the PSW along with other gestures were not all required to complete the resident's care.

As of March 10, 2020, PSW #118 had yet to complete these assigned courses.

As indicated by WN #5, related to O. Regulation 79/10, s.216, PSW #122 was reported in early 2020, by a co-worker for suspected verbal and emotional abuse. PSW #122 was also involved in an incident of alleged physical abuse in Inspection Report (#2019_617148_0029) issued November 1, 2019. The concern form reviewed indicated that PSW #122 was to complete assigned online learning related to recent concerns. The concern form noted that these courses had yet to be completed.

As indicated by WN #5, related to O. Regulation 79/10, s.216, PSW #104, PSW #118, SW #112, PSW #122 and PSW #125, have not been provided training on the licensee's policy to promote zero tolerance of abuse and neglect of residents.

The licensee has failed to protect residents from abuse and neglect in that training has not been completed as required by the LTCHA, 2007. In addition, when staff are

identified as requiring further training, due to involvement in incidents of alleged abuse or neglect, the licensee has failed to ensure that this training is completed.

4) As indicated by WN #4, related to O. Regulation 79/10, s. 99, the licensee has failed to ensure that an evaluation was made to determine effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents.

The severity of this issue was identified as minimal harm, however, section 19 has been identified as a key risk indicator and for this reason the level of severity was raised to actual risk of harm. The scope of the issue was widespread, as several residents were identified to be affected by the compliance issues; several staff were identified with training requirements lacking; and all residents are affected by the lack of evaluation of the policy to promote zero tolerance of abuse and neglect of residents. The home has previous non-compliance with section 19 of the LTCHA, 2007, as follows:

- Compliance Order (Inspection #2019_627138_0009), June 4, 2019. Closed June 25, 2019
- Compliance Order (Inspection #2019_761733_0001), March 5, 2019. Closed May 31, 2019

(148)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Oct 31, 2020(A1)

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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## 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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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:

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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.

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## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this 8 th day of July, 2020 (A1)**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Amended by AMANDA NIXON (148) - (A1)

Ontario

**Ministry of Long-Term Care**

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