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 sions de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 19, 2016	2016_200148_0014	010930-16	Critical Incident System

Licensee/Titulaire de permis

CITY OF OTTAWA
Long Term Care Branch 275 Perrier Avenue OTTAWA ON K1L 5C6

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

CARLETON LODGE
55 LODGE ROAD R. R. #2 NEPEAN ON K2C 3H1

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

AMANDA NIXON (148)

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): May 12 and 16, 2016.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Manager of Resident Care, Dietary Manager, RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), a Food Service Worker (FSW), Personal Support Workers (PSW), Educator, residents and family members.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

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

2 WN(s)
2 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. 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 failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

In accordance with O.Reg 79/10, s.2(1), sexual abuse means any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

The Manager of Resident Care identified the policy to promote zero tolerance of abuse and neglect of residents to be policy #750.65, titled Abuse, with revision/review date of February 2016. The policy indicates to report immediately any suspicion or allegation of resident abuse to the Charge Nurse, immediately report the allegation to the Administrator and Manager of Resident Care.

Resident #001 was recently admitted to the home. The resident propels him/herself around the home by use of a wheelchair and is able to participate in activities of daily living. The plan of care for resident #001 indicates communication and cognitive deficits.

The plan of care for resident #002 indicates communication and cognitive deficits and responsive behaviours to include physical and verbal aggression and socially inappropriate behaviours.

On a specified date, after the a meal service, FSW #101 observed resident #001 at the table of resident #002, the residents were kissing on the lips and resident #001 had a hand up the shirt of resident #002. FSW #101 reported the incident to her immediate supervisor, the Dietary Manager and to RN #104, who on this day was responsible for the unit which resident #001 resides.

On a specified date, RN #104 wrote a progress notes indicating that resident #001 was kissing a resident and touching inappropriately while in the main dining room. She noted that staff have been alerted and will monitor for recurrence of this behavior as resident has cognitive deficits. In an interview with RN #104, she reported that she alerted staff on the day shift and included the incident in her report to the evening shift staff.

The Critical Incident Report to the Director (MOHLTC), indicates that RN #105 was also aware of the incident. In an interview with the Inspector, RN #105 reported that she had overheard a maintenance staff member #102 talking about residents kissing. Staff member #102 then stated to RN #105 that he had observed resident #001 and #002 kissing in the dining room. RN #105 indicates she spoke with RN#104 and a decision was made to keep the residents separated and to monitor.

Inspector #148 confirmed that on the same date as the incident, the Manager of Resident Care was on site during regular business hours.

In an interview with FSW #101, the Dietary Manager, RN#104, RN#105 and staff member #102, it was confirmed that no immediate report of the incident was brought to the attention of the Manager of Resident Care or Administrator. On the afternoon of the day after the incident, RN #104 reported the incident to the Manger of Resident Care by email. [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 staff with any suspicion or allegation of resident abuse report the information as described by the home's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #2: 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 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 to the licensee, is immediately investigated.

In accordance with O.Reg 79/10, s.2(1), sexual abuse means 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.

As indicated by WN #1, an incident of alleged sexual abuse occurred on a specified date, between resident #001 and resident #002. The inspection conducted by Inspector #148 indicated that the incident was witnessed by FSW #101 and maintenance staff member #102. Registered staff including RN #104 and RN #105 and the home's Dietary Manger were also aware of the incident.

The day after the incident, the home's Manager of Resident Care was informed by RN #104 by email. The email was received by the Manger of Resident Care, after hours and therefore the home's Manager of Resident Care contacted the manager on call. Direction was provided for one on one monitoring and report to the Director (Ministry of Health and Long Term Care) through the after-hours pager.

The home's Manager of Resident Care returned to the home on five days after the incident. At this time the manager indicated that she reviewed the progress notes of

resident #001, submitted a Critical Incident Report, spoke with the home's Administrator and registered nursing staff. In an interview with Inspector #148, she indicated that the Administrator supported the incident to be consensual and that it was not sexual abuse. For this reason, the Manager of Resident care did not pursue an investigation. She did report to the Inspector that she suspected sexual abuse as there was kissing and inappropriate touching noted in the progress note and both residents have cognitive deficits. She spoke with RN #104 and RN #105 and asked them to initiate behavioural mapping and report any further incidents to her. She also requested the physician of resident #001 to assess the need for a medication used to manage sexual inhibition. During an interview with the Inspector, the Manager of Resident care was not clear as to what the "inappropriate touching" included in this incident and was not aware that the Dietary Manager also had information related to the incident.

It was confirmed that the Manager of Resident Care had not completed an immediate investigation into the incident, including but not limited to, interviewing witnesses to the incident, determining the extent of the report of inappropriate touching and determining the resident's capacity to consent.

In an interview with the home's Administrator, it was described that an investigation was expected to have been completed by the Manager of Resident Care. The Administrator had thought that such an investigation had been completed. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected or witnessed incident of sexual abuse that the licensee knows of is immediately investigated, to be implemented voluntarily.

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Issued on this 19th day of May, 2016

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

Original report signed by the inspector.