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 3, 2017	2017_673554_0021	008341-17, 009639-17, 017236-17	Critical Incident System

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Hope Street Terrace
20 HOPE STREET SOUTH PORT HOPE ON L1A 2M8

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

KELLY BURNS (554)

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): September 05-08, and September 12, 2017

Intakes #008341-17, 009639-17, and 017236-17

Summary of Intakes:
1) # 008341-17 - Critical Incident Report (CIR) - incident which causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status;
2) # 009639-17 - CIR - alleged sexual abuse of a resident;
3) # 017236-17 - CIR - alleged staff to resident physical/verbal abuse.

During the course of the inspection, the inspector(s) spoke with Administrator, Acting Director of Care, Program Manager, Environmental Services Supervisor, Food Services Worker, Registered Nurse(s), Registered Practical Nurse(s), Personal Support Workers, Maintenance Worker, Registered Dietitian, Family and residents.

During the course of the inspection, the inspector, toured the long-term care home, observed meal service, observed staff to resident interactions, resident to resident interactions, reviewed clinical health records, licensee investigations specific to assigned intakes, maintenance request binder, and reviewed licensee policies, specifically Zero Tolerance of Resident Abuse and Neglect, and Responsive Behaviours.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

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

5 WN(s)
4 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 that promotes zero tolerance of abuse and neglect of resident is complied with.

The licensee's policy, Zero Tolerance of Resident Abuse and Neglect Program states that the home will comply with all provincial, regional and local health authority written directives regarding Zero Tolerance of Abuse and Neglect.

The licensee's policy, Zero Tolerance of Resident Abuse and Neglect: Response and Reporting states that anyone who witnesses or suspects abuse or neglect of a resident, by another resident, staff, or other person must report the incident. The report may be made to the home and/or external authorities. At minimum, any individual who witnesses or suspects abuse or neglect of a resident must notify management immediately.

The Zero Tolerance of Resident Abuse and Neglect: Response and Reporting policy, directs the following:
- staff must complete an internal incident report and notify their supervisor (or during after-hours the nurse on site);
- the nurse on site would then call the Manager On-Call or General Manager/designate immediately upon suspecting or becoming aware of abuse or neglect of a resident;
- the Administrator, Director of Care, Supervisor or Designate will, immediately initiate an investigation, of the alleged, suspected or witnessed abuse; notify police as applicable; follow provincial specific reporting requirements, specifically in Ontario, required to contact the Ministry of Health and Long-Term Care Director, using the LTC (long-term care) Critical Incident Reporting Form, or the Action Line contact number;
- contact the Physician or Nurse Practitioner for further assessment if required and communicate the status of the resident;

- disclosure of the alleged abuse will be made to the substitute decision maker, immediately upon becoming aware of the incident;
- in Ontario, anyone who suspects or witnesses abuse or neglect that causes or may cause harm to a resident is required to contact the Ministry of Health and Long-Term Care through the Action Line at 1-866-434-0144.

Related to Intake #09639-17:

The Acting Director of Care submitted a Critical Incident Report (CIR) to the Director, on an identified date, specific to an alleged incident of abuse. As per the CIR, the alleged incident involved resident #003.

Resident #003 was admitted to the long-term care home on an identified date, and has a history which includes, cognitive impairment.

The clinical health record, for resident #003, was reviewed by the inspector, for the period of twenty-five days, with the following documented:

- On an identified date – (documented by Registered Nurse (RN) #104) - Resident #003 became upset and was crying during an identified time. Resident #003 told Resident #004 that he/she thinks he/she was abused.
- The next day (documented by RN #105) – Resident #003 is being monitored, as resident stated he/she had been abused.

The Director of Care indicated, to the inspector, that he/she was made aware of the alleged abuse, involving resident #003, three days later, while reviewing progress notes during report, and at this time, he/she began investigating the allegation. The Director of Care indicated that the investigation concluded, and it was determined, by him/herself and the Administrator, that other registered nursing staff, besides RN #104 had been aware of the alleged abuse of resident #003. The Director of Care, as well as the Administrator indicated, to the inspector, that Registered Practical Nurse (RPN) #103, and #115, as well as RN #105 and #114, also did not comply with the licensee's policies, specific to zero tolerance of abuse and neglect, as all registered nursing staff identified were aware of the allegation, of abuse, and failed to notify the administrative team (Administrator and or Director of Care), Ministry of Health and Long-Term Care, SDM, the physician and the police.

Registered Nurse #105, who was the Charge Nurse, on an identified date, indicated to

the inspector, that he/she reviewed progress notes, and saw RN #104's documented entry from the previous date, specific to the alleged abuse. RN #105 indicated he/she questioned RN #104 when RN #104 arrived for his/her assigned shift later that day; RN #105 indicated RN #104 stated resident #003 had indicated he/she thought he/she had been abused and complained of discomfort, but that RN #104 stated most likely resident #003 was mistaken. RN #105 indicated that he/she did not inquire as to the actions taken by RN #104, and assumed that RN #104 had followed the licensee's policy surrounding zero tolerance of abuse. RN #105 indicated taking no further action. RN #105 indicated, to the inspector, that he/she him/herself should have followed up, with RN #104, to ensure that proper notifications, and or reporting requirements had been followed as per the licensee's policy.

Registered Practical Nurse #103 indicated, to the inspector, that he/she was aware of the alleged abuse, involving resident #003, on the identified date, while providing report to the oncoming shift; RPN #103 indicated he/she read RN #104's documented entry in resident #003's health record, but did not question RN #104 as to if the licensee's policy had been followed, specifically around reporting the allegation. RPN #104 indicated taking no further action, as he/she assumed RN #104 was handling the abuse allegation. RPN #103 indicated, to the inspector, that he/she him/herself should have followed up, with RN #104, to ensure that proper notifications, and or reporting requirements had been followed as per the licensee's policy.

Registered Nursing Staff #104, 114, and #115 were not interviewed during this inspection.

The Director of Care and the Administrator indicated that the identified registered nursing staff (#103, 105, 114, and 115) who had awareness of the alleged abuse of resident #003, were aware of the licensee’s policies, surrounding zero tolerance of abuse and neglect, specifically around reporting and notification requirements. The Director of Care, and the Administrator both indicated all staff are expected to follow the licensee’s policies. [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 there is a process in place and monitored, ensuring that the written policy that promotes zero tolerance of abuse and neglect of resident is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that any person who has reasonable grounds to suspect, that abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

Under O. Reg. 79/10, s. 2 (1) - For the purposes of the definition of "abuse" in subsection 2 (1) of the Act,

- "sexual abuse" means, subject to subsection (3), any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed

towards a resident by a licensee or staff member, or 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;

- "physical abuse" means, the use of physical force by anyone other than a resident that causes physical injury, and or pain;

- "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;

Related to Intake #09639-17:

The Acting Director of Care submitted a Critical Incident Report (CIR) to the Director, on an identified date, specific to an alleged incident of abuse. As per the CIR, the alleged incident involved resident #003.

Resident #003 was admitted to the long-term care home on an identified date, and has a medical history which includes, cognitive impairment.

The clinical health record, for resident #003, was reviewed by the inspector, for the period of twenty-five days, with the following documented:

- On an identified date - Registered Nurse (RN) #104, who was the assigned Charge Nurse, documented resident #003 became upset during an identified time. Resident #003 told Resident #004 that he/she thinks he/she was abused.

Registered Nurse #104 indicated, in his/her written statement to the Director of Care three days later, that resident #003 had been on occasion (in the past) disoriented and upset during identified shifts; RN indicated, he/she (RN) provided reassurance, provided care and settled resident #003. RN #104 indicated, in his/her statement, that he/she, realized that he/she did not follow procedure regarding the abuse allegation, involving resident #003, indicating that he/she should have notified the Ministry of Health and Long-Term Care.

Registered Nurse #104 was not available for an interview during this inspection.

The Director of Care, and the Administrator both indicated, to the inspector, that the Director, Ministry of Health and Long-Term Care (MOHLTC) should have been notified immediately, by RN #104, of the alleged abuse of resident #003. DOC indicated that MOHLTC was not notified of the alleged abuse until three days following the incident. [s. 24. (1)]

2. Related to Intake #017236-17:

The Director of Care submitted a Critical Incident Report (CIR) to the Director, on an identified date, regarding an alleged incident of staff to resident abuse. As per the CIR, the alleged abuse incident occurred a day earlier, and involved resident #005.

Documentation in the CIR contains the following:

- Resident #005 was attempting to get him/herself a beverage, from the resident home area fridge, Personal Support Worker (PSW) #108 was overheard by Activity Aid (AA) #107 speaking to resident #005 in an abrupt manner, stating, to resident #005 'no, you cannot have any; I told you to get out of the fridge'. Activity Aid #107 observed PSW #108 placing his/her hands on resident #005 and pushing the resident in the opposite direction. Activity Aid #107 intervened, assisted resident to another area and provided resident with the requested beverage. Activity Aid #107 reported what he/she had witnessed to Registered Nurse (RN) #104.

Resident #005 has a history which includes cognitive impairment.

The clinical health record, for resident #003, was reviewed by the inspector, for the period of approximately one and a half months, with the following documented:

- There is no documented entry, on the identified date, related to the alleged staff to resident abuse incident.

The Director of Care (DOC) indicated, to the inspector, that he/she was first aware of the alleged incident of staff to resident abuse, involving PSW #108 and resident #005 a day following the incident. Director of Care indicated that an investigation was initiated at that time, which included an interview with Registered Nurse (RN) #104, who was the identified shift Charge Nurse assigned on the identified date.

Registered Nurse #104 indicated, in his/her written statement to the Director of Care, that

AA #107 reported (to him/her, RN #104), that PSW #108 was overheard speaking to resident #005 in an abrupt manner, refusing resident a beverage, and observed placing his/her (PSW #108) hands on resident #005 and pushing the resident in the opposite direction. RN #104 indicated speaking to PSW #108 who indicated (to the RN) that he/she perhaps spoke with resident #005 in an abrupt manner, but did not recall touching the resident. RN indicated that resident #005 could not recall the incident, so no further action was taken.

Registered Nurse #104 was unavailable for an interview during this inspection.

The Director of Care indicated, that the licensee's investigation concluded; DOC indicated that RN #104 should have reported the alleged staff to resident abuse incident to the Ministry of Health and Long-Term Care, during his/her shift on the identified date. [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 there is a process in place and monitored, ensuring that any person who has reasonable grounds to suspect, that abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee failed to ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents.

Registered Nurse #100, the Director of Care, and the Administrator, all indicated, to the inspector, that an identified device would be considered medical equipment, and that such is used for the nursing and personal care needs of residents.

Related to Intake #008341-17:

Registered Nurse (RN) #100 submitted a Critical Incident Report (CIR) to the Director, on an identified date, specific to an incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status. Resident #002 was involved in an incident two days earlier, sustained injury and was transferred to hospital for assessment.

Resident #002 was admitted to the long-term care home on an identified date. Resident has a history which includes cognitive impairment. Resident #002 requires extensive assistance for activities of daily living, including transfers and toileting; resident uses a mobility aid as his/her primary mode of transportation, and is at risk for falls.

The clinical health record, for resident #002, was reviewed for the period of approximately one and a half months, with the following documented.

Risk Management:
- Identified Incident, documented by RN #104 (on an identified date) - the identified medical equipment, supplied by the long-term care home, came off the toilet causing resident #002 to have an incident. Resident sustained injury and was transferred to hospital.

Progress Notes:
- On an identified date – RN #100 indicated in the progress note that SDM (substitute decision maker) for resident #002 voiced concern that the identified medical equipment (supplied by the home), in resident's identified area had tipped forward. RN #100 indicated, in his/her progress note, telling the SDM that he/she would have maintenance inspect it for any repairs needed.
- On an identified date (approximately fifty-two day later)– RN #104 heard a personal alarm ringing as he/she (the RN) was coming down the hallway, and then heard a 'crash'; RN indicated, in his/her documentation, that he/she found resident #002 on the floor in an identified area. Resident #002 indicated, to the RN, that he/she was hurt. RN #104 documented that the identified medical equipment (supplied by the home) was on the floor. RN #104 indicated, in his/her documentation, that it appeared that resident

#002 had grabbed the identified medical equipment to pull him/herself up and the identified medical equipment had come off, causing the resident to have an incident.

Resident #002 was transferred to the hospital for assessment and treatment, on the same date. While at the hospital resident #002 was diagnosed to have specific injuries. Resident was discharged from the hospital, returning to the long-term care home on that same date. The next day, resident was experiencing unmanageable symptoms, and was transferred back to hospital. Resident did not return to the long-term care home.

Registered Nurse #100 indicated, to the inspector, that he/she placed SDM’s concern, regarding the identified medical equipment (supplied by the long-term care home) needing inspection and repair into the Maintenance Request binder for follow up. RN #100 indicated 'he/she assumed maintenance would make the necessary repairs'. RN #100 indicated that the concerns addressed, by resident #002's, SDM were communicated to the management team, specifically the Director of Care and the Administrator, during report the day the concerns were received or the next day; RN #100 could not recall the exact date.

The Maintenance Request binder was reviewed, by the inspector, with the following documented:
- On an identified date – Please secure the identified medical equipment in resident #002’s identified area. The response by maintenance, is documented as 'they (the identified medical equipment) are friction fit; no way to secure’. The entry by maintenance is not dated, but is initialled by Maintenance Worker #112.

Maintenance Worker #112 indicated, to the inspector, that he/she placed the comment in the maintenance request binder, indicating that the identified medical equipment (home supplied) in resident #002’s identified area could not be secured. Maintenance Worker #112 indicated that 'the identified medical equipment was screwed onto the identified area, and that any movement by a resident, in any direction, while seated on the identified medical device would loosen the friction fit seal, causing the identified medical equipment to become loose'. Maintenance Worker indicated 'the identified medical equipment were old, and that staff often complained that they needed to be tightened'. Maintenance Worker #112 indicated that at the time the identified medical equipment were the only style used within the long-term care home. Maintenance Worker #112 indicated, to the inspector, that he/she had brought forth the concern, regarding being unable to secure the identified medical equipment, in resident #002’s to the Administrator, as well as RN #100. Maintenance Worker #112 indicated that no further

action was taken by him/her with regards to the identified medical equipment.

Maintenance Worker #112 indicated that concerns regarding ‘securing identified medical equipment, and the potential of it becoming loose with use’ had been communicated to registered nursing staff, specifically RN #100, Environmental Services Supervisor and the Administrator on more than one occasion’.

Environmental Services Supervisor (ESS), who manages Maintenance Worker #112, and the Administrator, both indicated, to the inspector, that they do not recall the Maintenance Worker bringing concerns forward to them regarding ‘being unable to secure the identified medical equipment’. Both indicated concerns regarding ‘the inability to secure the identified medical equipment’ came forward during the investigation of resident #002’s incident.

Personal Support Worker #101 and #102 indicated, to the inspector, that the identified medical equipment were removed from resident identified area, and no longer in used by the home, following a identified incident. PSW’s #101 and #102 indicated that the identified medical equipment were constantly needing to be tightened, as they easily became loose; both indicated that the identified medical equipment were old and that the screw mechanism on many of the identified medical equipment had been 'stripped' from constant tightening. PSW's indicated concerns regarding the loose fitting identified medical equipment were placed into the maintenance request binders, as well as had been communicated to registered nursing staff and management in the past.

The Administrator indicated, that it is an expectation equipment and or devices, such as the identified medical equipment, are available (at the home) to meet the nursing and personal care needs of residents. The Administrator indicated, to the inspector, that the Maintenance Worker stating the ‘identified medical equipment could not be secured’ was not acceptable, and that alternative action should have been taken. [s. 44.]

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 there is a process in place and monitored, ensuring that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Related to Intake #09639-17:

The Acting Director of Care submitted a Critical Incident Report (CIR) to the Director, on an identified date, specific to an alleged incident of abuse. As per the CIR, the alleged incident involved resident #003.

Resident #003 has a history which includes, cognitive impairment.

The clinical health record, for resident #003, was reviewed by the inspector, for the period identified, with the following documented:

- On an identified date - Registered Nurse (RN) #104, who was the assigned Charge Nurse, documented, resident #003 became upset. Resident #003 told Resident #004 that he/she thinks he/she was abused. Resident #003 indicated having some discomfort

to an identified area.

Registered Nurse #104 indicated, in his/her written statement, to the Director of Care, three days later, that resident #003 had been on occasion (in the past) disoriented and upset during identified shifts, hence the reason he/she (RN) provided reassurance, provided care and settled resident #003 into bed. RN #104 indicated, in his/her statement, that he/she, realized that he/she did not follow procedure regarding the abuse allegation, involving resident #003, indicating that he/she should have notified the police.

Registered Nurse #104 was not available for an interview during this inspection.

The Director of Care, and the Administrator both indicated, to the inspector, that the police should have been notified immediately, by RN #104, of the alleged abuse of resident #003. DOC indicated that the police were not notified of the alleged abuse until three days following the incident.

Police investigated the alleged abuse, involving resident #003, the allegation was unfounded. [s. 98.]

2. Related to Intake #017236-17:

The Director of Care submitted a Critical Incident Report (CIR) to the Director, on an identified date, regarding an alleged incident of staff to resident abuse. As per the CIR, the alleged abuse incident occurred a day earlier, and involved resident #005.

Documentation in the CIR contains the following:

- Resident #005 was attempting to get him/herself a beverage, from the resident home area fridge, Personal Support Worker (PSW) #108 was overheard by Activity Aid (AA) #107 speaking to resident #005 in an abrupt manner, stating, to resident #005, 'no, you cannot have any more; I told you to get out of the fridge'. Activity Aid #107 observed PSW #108 placing his/her hands on resident #005 and pushing resident in the opposite direction. Activity Aid #107 intervened, assisted resident to another area and provided resident with the requested beverage. Activity Aid #107 reported what he/she had witnessed to Registered Nurse (RN) #104.

Registered Nurse #104 indicated, in his/her written statement to the Director of Care on an identified date, that AA #107 reported (to him/her, RN #104), what he/she had

observed between PSW #108 and resident #005; AA indicated that the actions of PSW #108 were abusive. RN #104 indicated speaking to PSW #108 who indicated that he/she perhaps spoke with resident #005 in an abrupt manner, but he/she did not recall touching the resident. Resident #005 could not recall the incident.

Registered Nurse #104 and AA #107 were not available for an interview during this inspection.

The Director of Care, and the Administrator both indicated, to the inspector, that the police should have been notified immediately, by RN #104, of the alleged physical abuse of resident #005. DOC indicated that the police were not notified of the alleged abuse until the following day.

Police investigated the alleged physical abuse, involving resident #005, as per the Director of Care no charges were issued. [s. 98.]

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 there is a process in place and monitored, ensuring that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #5: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's SDM (substitute decision maker) and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of a resident that, resulted in physical injury or pain to a resident, or caused distress to the resident that could potentially be detrimental to the resident's health or well being.

Related to Intake #09639-17:

The Acting Director of Care submitted a Critical Incident Report (CIR) to the Director, on an identified date, specific to an alleged incident of abuse. As per the CIR, the alleged incident involved resident #003.

Resident #003 has a history which includes, cognitive impairment. Resident #003 has a designated SDM.

The clinical health record, for resident #003, was reviewed by the inspector, for the period of twenty-five days, with the following documented:

- On an identified date - Registered Nurse (RN) #104, who was the assigned Charge Nurse, documented, resident #003 became upset during an identified time. Resident #003 told Resident #004 that he/she thinks he/she was abused. Resident #003 indicated having some discomfort. RN #104 provided resident #003 reassurance, assisted resident to an identified area, and provided resident care.

There is no supporting documentation, to indicate that the SDM, for resident #003, was immediately notified of the alleged abuse.

Registered Nurse #104 indicated, in his/her written statement to the Director of Care on an identified date, three days following the alleged incident, that he/she, realized that he/she did not follow procedure regarding the abuse allegation, involving resident #003, indicating that he/she should have notified the resident's SDM.

Registered Nurse #104 was not available for an interview during this inspection.

The Director of Care, and the Administrator both indicated, to the inspector, that the SDM for resident #003 was not notified of the alleged abuse until three days following the incident. Both indicated that the SDM, for resident #003, should have been notified immediately of the abuse allegation. [s. 97. (1) (a)]

Issued on this 4th day of October, 2017

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

Original report signed by the inspector.