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 prévue 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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 3, 2019	2019_591623_0005	028360-17, 028927-17, 001108-18, 010686-18, 010868-18, 022225-18, 025232-18, 030421-18, 030838-18, 031161-18, 002842-19, 004603-19, 004819-19, 004864-19	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Port Perry Place
15941 Simcoe Street Port Perry ON L9L 1N5

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

SARAH GILLIS (623)

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 28, 29, April 1-5, 9-12, 15-18, 23 -26, 2019

The following Critical Incident intakes were inspected:
Log #028927-17 related to alleged resident to resident abuse.
Log #004864-19 related to alleged resident to resident abuse.
Log #028360-17 related to alleged staff to resident abuse.
Log #001108-18 related to alleged improper care.
Log #010686-18 related to alleged staff to resident abuse.
Log #010868-18 related to alleged staff to resident abuse.
Log #022225-18 related to alleged staff to resident abuse.
Log #025232-18 related to alleged staff to resident abuse.
Log #030421-18 related to alleged staff to resident abuse.
Log #030838-18 related to alleged staff to resident abuse.
Log #031161-18 related to alleged staff to resident abuse.
Log #002842-19 related to alleged staff to resident abuse.
Log #004603-19 related to alleged staff to resident abuse
Log #004819-19 related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), former Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Worker (PSW), Nursing Clerk, Office Manager, and residents.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

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

- **5 WN(s)**
- **5 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	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for resident #017 was provided to the resident as specified in the plan related to the identified responsive behaviour of refusing care.

Related to Log # 010686-18

A critical incident report (CIR) was submitted to the Director, for an incident of alleged staff to resident physical abuse that occurred on a specified, and was reported on a specified date.

On a specified date, PSW #139 reported to RPN #110 that on a specified date, on a specified shift, resident #017 refused to allow the PSW staff to provide specific care. When the staff approached the resident, the resident would state "no" and close their bedroom door. PSW #139 indicated that staff would leave and attempt again later, this continued throughout the shift. PSW #139 indicated that near the end of the shift RN #126 informed the PSW staff on duty that not providing care to a resident was abuse, the resident doesn't know any better, the resident is confused. RN #126 instructed the staff that all of them needed to go together and ensure that the care is completed. RN #126, Agency RPN, PSW #137, PSW #138, PSW #139 and PSW #134 all attended the room. RN #126 assisted PSW staff to hold resident #017 down so the resident could not strike out or kick at the staff while care was provided. PSW #139 indicated to the RPN that they did not feel this was right, but RN #126 told the staff that they had to do it or they would be reported.

Resident #017 was admitted to the home with specified diagnosis and exhibited specific identified responsive behaviours and triggers were identified.

Review of the written plan of care that was in place at the time of the incident, was

completed by Inspector #623. The plan of care identified that two staff were to provide care, using a calm approach and let the resident do as much as they can on their own.

Review of the licensee's internal investigation including interview notes indicated that PSW's #137, #138, #139 and #134 each provided written details of the events that occurred leading up to the incident. All four PSW's indicated in their written statements that resident #017 had been approached by staff hourly throughout the shift, and each time the resident refused care. The PSW's each indicated that every refusal was documented in Point of Care (POC) and reported to the RPN (agency) as well as RN #126. The PSW's indicated that near the end of their shift, RN #126 instructed the four PSW's and the agency RPN to accompany the RN to resident #017's room. The six staff assisted to provide care to the resident while RN #126 held the residents hands down against their stomach and the resident was reported to be resisting as care was provided.

On a specific date and time during an interview with Inspector #623, RPN #109 indicated, that resident #017 was experiencing resistive to care episodes and was placed in the restorative program. Restorative staff worked with resident #017 to maintain their ability in specified areas to maintain independence. It was identified that for resident #017, "No means No". The resident was never overly cooperative when they decided that they were not going to do something. The expectation for PSW staff would be to reproach and try later, if the end of the shift came and staff had not been able to provide care, then PSW staff needed to pass it on to the next shift, or try a different staff member. RPN #109 indicated that if care could not be completed, the Point of Care (POC) charting should reflect this as well as the progress notes.

On a specific date and time, during an interview with Inspector #623, BSO RPN #110 indicated that the plan of care for resident #017 was specific to the identified responsive behaviours. The plan of care identified specific triggers for the identified behaviours. Interventions included two staff were to provide care using a calm approach and allowing the resident to complete as much of their care on their own that was possible. The written plan of care also indicated that staff were to monitor episodes of responsive behaviours and attempt to determine what the underlying cause was. Staff were expected to document when behaviours occurred and include details about what was happening at the time. RPN #110 indicated that the expectation is that if a resident refuses care then the staff should make the resident safe, leave and reproached at a later time. PSW's are expected to document in POC and send an alert to the registered staff so that they know care was refused. This should be documented for every approach. If a PSW is unable to

provide care to a resident after several attempts, then they should report this to the registered staff so that other possible interventions could be looked at and all possibilities should be considered.

On a specific date and time during a telephone interview with Inspector #623, the former DOC indicated that the expectation of the licensee was that care would be provided to residents in accordance to their plan of care. The former DOC indicated that the staff were not following the written plan of care for resident #017, when six staff approached the resident and held the resident down while care was provided despite the resident's refusal.

During this inspection PSW's #137, #138, #139 and #134 as well as RN #126 were not available for interview.

The licensee failed to ensure that the care set out in the plan of care for resident #017 was provided to the resident as specified in the plan specific to the identified responsive behaviour. [s. 6. (7)]

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 by ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, 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 has failed to ensure that the person who had reasonable grounds to suspect that improper or incompetent treatment of care of a resident, abuse of a resident by anyone or neglect of a resident by the licensee or staff, that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

Related to Log # 010686-18

1. A critical incident report (CIR) was submitted to the Director, for an incident of alleged staff to resident physical abuse that occurred on a specified date, and was reported the following day. The CIR indicated the following:

On a specified date, PSW #139 reported to RPN #110 that the day prior, resident #017 refused to allow the PSW staff to provide care. When the staff approached the resident, the resident would state "no" and close their bedroom door. PSW #139 indicated that staff would leave and attempt again later, this continued throughout the shift. PSW #138 indicated that near the end of the shift, RN #126 informed the PSW staff on duty that leaving a resident without care being provided was abuse. RN #126 instructed the staff that all of them needed to go together and ensure that the care was completed. RN #126, Agency RPN, PSW #137, PSW #138, PSW #139 and PSW #134 all attended the room. RN #126 held resident #017 down by holding the residents arms so they could not

strike out at the staff. PSW #137 had their hands on the resident's feet so they could not kick. PSW #139 indicated to the RPN that they did not feel this was right, but RN #126 told the staff that they had to do it or they would be reported.

On a specified date and time, during an interview with Inspector #623, Behavioural Support RPN #110 indicated that on a specified date, they were speaking to the PSW staff regarding the proper approach with resident #017. PSW #138 indicated "that is not what happened last night". RPN #110 asked for clarification and PSW #138 indicated, there were six staff who held resident #017 down to provide care, when the resident refused, as directed by RN #126. RPN #110 indicated that once becoming aware, they reminded PSW #138 of their duty to report immediately, any witnessed or suspected abuse. RPN #110 then immediately reported the incident to the former DOC.

On a specified date and time, during a telephone interview with Inspector #623, the former DOC indicated that the incident occurred on a specific date, but was not reported to RPN #110 until the following afternoon, by PSW #138 who was present at the time of the incident. The former DOC indicated that they first became aware of the incident on the same date. The former DOC indicated that an investigation was initiated immediately which included a report to the Director. The former DOC indicated that the expectation of the licensee is that any alleged, suspected or witnessed improper or incompetent treatment of a resident or suspected abuse or neglect of a resident that resulted in harm or risk of harm, is reported immediately.

The licensee failed to ensure that the person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident, or abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director. When RN #126 instructed the Agency RPN, PSW #137, PSW #138, PSW #139 and PSW #134, to provide care to resident #017, against their wishes, while RN #126 held the resident down. [s. 24. (1)]

2. On a specified date and time, an incident of witnessed staff to resident abuse occurred when PSW #101 observed PSW #134 assisting resident #022 into bed. The resident was repeatedly stating that they were in pain. PSW #101 observed PSW #134 push and shove resident #022 into their bed. Resident #022 was then observed by PSW #101 to reach for a glass of water that was at the bedside, and proceed to throw the water at PSW #134. PSW #134 then left the resident room and once in the hallway, the PSW made a comment to PSW #101 about resident #022. RN #106 was in close proximity and

overheard the incident. PSW #101 indicated that the RN laughed because the resident threw the water and did not treat the incident as abuse.

On a specified date, PSW #101 informed the ED by email of the incident that had occurred four days prior.

On a specified date and time, during an interview with Inspector #623, the ED provided investigation notes including the email that PSW #101 had sent. The ED indicated that an investigation was conducted by the former DOC which included interview with PSW #134, PSW #101 and RN #106. The ED indicated that this investigation did not take place until two days after the email was received, and a CIR was not submitted to the Director. The ED indicated that the expectation of the licensee is that when abuse of a resident is alleged, suspected or witnessed, a PSW would immediately report the incident of abuse to someone in a supervisory position. Once the PSW reports to an RN, then the RN should begin the investigation including contacting management. The ED indicated that the PSW should provide a written statement at the time the incident is reported to the RN.

On a specified date and time, during a telephone interview with Inspector #623, the former DOC indicated there was an incident that had occurred on a specified date, involving resident #022, that was reported to the RN's at the time of the incident by PSW #101. Details of the incident were submitted in writing by email to the ED three days later when PSW #101 realized that nothing had become of the initial report. The former DOC indicated that there was an investigation into the alleged incident of abuse but that no CIR was submitted for the incident involving resident #022. The former DOC indicated that the Director was not notified.

The licensee failed to ensure that the alleged incident of physical and verbal abuse towards resident #022 that occurred on a specified date, was immediately reported to the Director. [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 by ensuring that the person who had reasonable grounds to suspect that improper or incompetent treatment of care of a resident, 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 has occurred, 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. 47. Qualifications of personal support workers

Specifically failed to comply with the following:

s. 47. (1) Every licensee of a long-term care home shall ensure that on and after January 1, 2016, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title,
(a) has successfully completed a personal support worker program that meets the requirements in subsection (2); and
(b) has provided the licensee with proof of graduation issued by the education provider. O. Reg. 399/15, s. 1.

Findings/Faits saillants :

1. The licensee has failed to ensure that all the persons hired on or after January 1, 2016 as personal support workers or to provide personal support services, regardless of title, has successfully completed a personal support worker program that meets the requirements listed below and has provided the licensee with proof of graduation issued by the education provider.

Agency Staff

(2) In subsection (1),
"agency staff" means staff who work at the long-term care home pursuant to a contract between the licensee and an employment agency or other third party. 2007, c. 8, s. 74

(2).

When agency staff is hired

s. 75 (3) For the purposes of subsection (1), a staff member who is agency staff, as the term is defined in subsection 74 (2), is considered to be hired when he or she first works at the home. 2007, c. 8, s. 75 (3).

Related to log #00242-19

1. A critical incident report (CIR) was submitted to the Director on a specified date, for an incident of alleged staff to resident physical abuse that occurred on a specified date.

On a specified date and time, during an interview with Inspector #623, the Executive Director (ED) indicated that the CIR was investigated by the former DOC. Initially it was reported as an unexplained alteration in skin integrity when resident #003 presented with a specific identified mark, when the PSW staff approached to provide care. RN #104 completed a head to toe assessment, notified the SDM and the physician. The physician indicated that they were unable to see the resident that day and recommended that the other physician complete an assessment if they were in the building. The resident was seen by the other MD and they suggested that the dentist see if there was a possible concern. The RN arranged for resident #003 to be assessed by the dentist, the dentist did not find any dental concerns. That night at a specified time resident #003 was sitting in a specified resident area as the staff were changing shift. The resident stated to PSW #102 that they were abused by "that person" and pointed at agency PSW #100 who was just coming on shift. The ED indicated that PSW #102 immediately reported the new information to RN #105, who removed PSW #100 from duty, contacted the police and reported to the ED and Director the allegation of abuse.

On a specified date, the ED indicated that during the licensee's investigation, they discovered that PSW #100 who worked for the home through a specific identified agency, did not actually have a certification as a PSW. The ED indicated that the home trusts that the agencies will send qualified people and will do the background checks before sending the staff to work in the home. The ED also indicated that they expect that the agency will complete a screening of potential staff. The ED indicated that they did not have a record of qualifications as a PSW for agency PSW #100, and did not verify the qualifications prior to the PSW starting to work in the home. The ED provided copies of PSW #100's school transcript which identified the first semester of the practical nursing

program. The ED indicated that this information was provided by the agency, when the licensee requested proof of certification and a police record check for PSW #100, after the allegation of physical abuse incident that occurred on a specified date, but not before.

On a specified date and time during an interview with Inspector #623, the Nursing Clerk indicated the first date PSW #100 worked in the home. There were a number of identified dates in a specified time period, when PSW #100 worked in the home. The Nursing Clerk indicated that it does not appear as though agency PSW #100 worked in the home before the on line education was completed. The Nursing Clerk indicated that agency PSW #100 has not worked in the home since a specified date. [s. 47. (1)]

2. Related to log #031161-18

A critical incident report (CIR) was submitted to the Director on a specified date, for an allegation of staff to resident abuse that was discovered on a specified date. The licensee notified the after-hours pager at the time the incident was discovered.

The CIR indicated that on a specified date and time, PSW #112 reported to RPN #113 regarding two marks on a specified area of resident #009 that the PSW noted while providing care. PSW #112 stated that they did not see the marks present the day before, when care was provided. PSW #112 asked resident #009 how the marks happened and the resident stated "last night, the PSW is rough" and provided a description of the PSW. When RPN #113 assessed resident #009, they was asked how the marks occurred and the resident was not aware. RPN #113 assessed the area and noted two marks close to each other on a specific identified area. RN #105 was notified of the incident and also completed an assessment of resident #009 noting the same alteration in skin integrity. RN #105 asked the resident if they knew what had occurred. Resident #009 was unable to recall the time but stated a PSW was rough while assisting the resident to and from the bathroom to their chair. The resident did not recall the details and stated that they didn't notice the marks until asked about it by PSW #112. RN #105 asked if resident #009 if they could identify the PSW and the resident described the agency PSW #111.

On a specific date and time during an interview with Inspector #623, the ED indicated that PSW #111 worked for the home through a specific agency. The ED indicated that they did not have on file a record of qualification as a PSW for agency PSW #111. The ED indicated that the home trusts that the agencies will send qualified people and the agency will do the background checks before sending the staff to work in the home. The

ED indicated that there is no personal file kept for agency staff who work in the home.

On a specific date and time during an interview with Inspector #623, the Office Manager indicated that after reviewing the business file, it was determined that PSW #111 began work in the home on a specified date, and worked a total of eight shifts in the home before being terminated from the home. The Office Manager indicated that there is no record that PSW #111 had successfully completed a personal support worker program that meets the legislated requirements and had not provided the licensee with proof of graduation issued by the education provider. [s. 47. (1)]

3. Related to Log #022225-18

A critical incident report (CIR) was submitted to the Director on a specified date, for an alleged incident of staff to resident physical abuse that occurred on the same date. The CIR indicated the following:

On a specific date and time, PSW #123 and agency PSW #122 discovered resident #014 standing in their room. PSW #123 left the room to retrieve supplies and left PSW #122 to care for the resident. When PSW #123 returned they observed PSW #122 taking resident #014 by the wrist towards the bathroom, the resident was saying "No" and resisting. PSW #123 told PSW #122 to leave resident #014 and they would return when the resident had calmed down. PSW #122 refused to listen to PSW #123 and continued to pull resident #014 into the bathroom and made the resident sit on the toilet. PSW #123 then told PSW #122 that they would finish the care for resident #014 and that PSW #122 could leave. PSW #123 then noticed specific marks on resident #014 in a specified area and the resident indicated that someone caused the marks. PSW #123 immediately reported the discovery to RPN #121.

On a specific date and time, during a telephone interview with Inspector #623, the former DOC indicated that PSW #122 was hired through a specified agency to work in the home. The former DOC indicated that they did not have a record of qualification as a PSW for agency PSW #122 and also indicated that this is not something they would typically ask for when hiring agency staff. The former DOC indicated that if a record was on file, RPN #124 who is responsible for staff education, would have kept a record.

On a specific date and time during an interview with Inspector #623, RPN #124 indicated that at the time PSW #122 was hired through the agency, it was not the practice of the licensee to obtain proof of certification or a police records check for any staff that were

hired through a nursing agency. RPN #124 indicated that it was expected that the agency would have completed these checks and would only be sending qualified staff to provide relief to the home.

During an interview with Inspector #623, the ED indicated that prior to a specified date, there were no records kept for any agency staff that were hired to work in the home, which included a record that PSW #122 had successfully completed a personal support worker program that meets the legislated requirements and had not provided the licensee with proof of graduation issued by the education provider.

The licensee failed to ensure that all persons hired on or after January 1, 2016, as personal support workers or to provide personal support services, regardless of title, has successfully completed a personal support worker program that meets the legislated requirements and has provided the licensee with proof of graduation issued by the education provider. [s. 47. (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 by ensuring that all the persons hired on or after January 1, 2016 as personal support workers or to provide personal support services, regardless of title, has successfully completed a personal support worker program that meets the requirements listed below and has provided the licensee with proof of graduation issued by the education provider, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include police record checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2); 2015, c. 30, s. 24 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that police record checks are conducted prior to hiring the staff member and/or accepting a volunteer who is 18 years of age or older.

s. 75 (1) Every licensee of a long-term care home shall ensure that screening measures are conducted in accordance with the regulations before hiring staff and accepting volunteers. 2007, c. 8, s. 75 (1).

(2) The screening measures shall include police records checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75 (2).

O. Reg. 79/10, s. 215 (1) This section applies where a police records check is required before a licensee hires a staff member or accepts a volunteer as set out in subsection 75 (2) of the Act.

(2) The police records check must be,
(a) conducted by a police force; and
(b) conducted within six months before the staff member is hired or the volunteer is accepted by the licensee.

Agency Staff
(2) In subsection (1),
"agency staff" means staff who work at the long-term care home pursuant to a contract between the licensee and an employment agency or other third party. 2007, c. 8, s. 74 (2).

When agency staff is hired
s. 75 (3) For the purposes of subsection (1), a staff member who is agency staff, as the term is defined in subsection 74 (2), is considered to be hired when he or she first works at the home. 2007, c. 8, s. 75 (3).

1. Related to log #00242-19

A critical incident report (CIR) was submitted to the Director on a specified date, for an incident of alleged staff to resident physical abuse.

On a specified date and time, during an interview with Inspector #623, the Executive Director (ED) indicated that the CIR was investigated by the former DOC. Initially it was reported as an alteration in skin integrity, when resident #003 presented with a mark on a

specified area, when the PSW staff approached to provide care. The ED indicated that during the licensee's investigation, they discovered that PSW #100 who worked for the home through an agency, did not have a police records check completed within six months prior to beginning work in the home. The ED indicated that the home trusts that the agencies will send qualified people and will do the background checks before sending the staff to work in the home, which would include a police records check when the agency screens potential staff. The ED indicated that they did not have on file for PSW #100 verification of a police record check that was completed prior to them starting work in the home.

On specific date and time during an interview with Inspector #623, the Nursing Clerk indicated that the first date identified for PSW #100 to work in the home. There were a number of identified dates over a specified period of time when PSW #100 worked in the home. The Nursing Clerk indicated that it does not appear as though agency PSW #100 provided a police records check to the home prior to beginning work. The Nursing Clerk indicated that agency PSW #100 has not worked in the home since a specified date. [s. 75. (2)]

2. Related to log #031161-18

A critical incident report (CIR) was submitted to the Director on November 26, 2018, for an allegation of staff to resident abuse that was discovered on a specified date. The licensee notified the after-hours pager at the time the incident was discovered.

On a specified date and time PSW #112 reported to RPN #113 regarding two marks on a specified area of resident #009 that the PSW noted while providing care. PSW #112 stated that they did not see the marks present the day before, when care was provided. PSW #112 asked resident #009 how the marks happened and the resident stated "last night, the PSW is rough" and provided a description of the PSW. When RPN #113 assessed resident #009, they was asked how the marks occurred and the resident indicated that they were not aware. RPN #113 assessed the area and noted two marks close to each other on a specific identified area. RN #105 was notified of the incident and also completed an assessment of resident #009 noting the same alteration in skin integrity. RN #105 asked the resident if they knew what had occurred. Resident #009 was unable to recall the time but stated a PSW was rough while assisting the resident to and from the bathroom to their chair. The resident did not recall the details and stated that they didn't notice the marks until asked about it by PSW #112. RN #105 asked if resident #009 if they could identify the PSW and the resident described the agency PSW

#111.

During an interview with Inspector #623, the ED indicated that PSW #111 worked for the home through a specified agency. The ED indicated that they did not have on file a record for agency PSW #111 of a police record check that was completed within six months prior to them starting work in the home. The ED indicated that the home had trusted that the agencies would send qualified people and the agency would do the background checks before sending the staff to work in the home. The ED indicated that there is no personal file kept for agency staff in the home.

During an interview with Inspector #623, the Office Manager indicated that after reviewing the business file, it was determined that PSW #111 began work in the home on a specified date, and worked a total of eight shifts in the home before being terminated. The Office Manager indicated that they did not have a police record check on file for agency PSW #111. [s. 75. (2)]

3. Related to Log #022225-18

A critical incident report (CIR) was submitted to the Director on a specified date, for an alleged incident of staff to resident physical abuse that occurred on the same date. The CIR indicated the following:

On a specific date and time, PSW #123 and agency PSW #122 discovered resident #014 standing in their room. PSW #123 left the room to retrieve supplies and left PSW #122 to care for the resident. When PSW #123 returned they observed PSW #122 taking resident #014 by the wrist towards the bathroom, the resident was saying “No” and resisting. PSW #123 told PSW #122 to leave resident #014 and they would return when the resident had calmed down. PSW #122 refused to listen to PSW #123 and continued to pull resident #014 into the bathroom and made the resident sit on the toilet. PSW #123 then told PSW #122 that they would finish the care for resident #014 and that PSW #122 could leave. PSW #123 then noticed specific marks on resident #014 in a specified area and the resident stated “someone hurt me”. PSW #123 immediately reported the discovery to RPN #121.

Review of the licensee's internal records by Inspector #623, indicated that agency PSW #122 worked in the home on 70 occasions over a specified period of time.

During a telephone interview with Inspector #623, the former DOC indicated that when

the alleged incident of physical abuse was reported on a specified date, the former DOC initiated an investigation which included informing the agency that PSW #122 would not be permitted back pending the investigation. The former DOC indicated that PSW #122 did not return to the home following this incident, the agency was notified that PSW #122's services were no longer required. The former DOC indicated that they did not complete a background police records check of agency staff PSW #122 prior to their first shift in the home.

During an interview with Inspector #623, the ED indicated that prior to February 2019, there were no records kept for any agency staff that were hired to work in the home, which included a current police records check.

The licensee failed to ensure that screening measures are conducted in accordance with the regulations before hiring staff and accepting volunteers which includes a police records check that is required before a licensee hires a staff member or accepts a volunteer. The police records check must be conducted by a police force and conducted within six months before the staff member is hired or the volunteer is accepted by the licensee. The licensee failed to complete a police records check for PSW #122, PSW #111 and PSW #100, who were hired to work in the home through an agency, prior to being hired in the home. [s. 75. (2)]

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 by ensuring that police record checks are conducted prior to hiring the staff member and/or accepting a volunteer who is 18 years of age or older, 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 has failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

During the review of the licensee's investigation for log #004819-19, Inspector #623 discovered interview notes with PSW #134 and PSW #101 and the former DOC, which pertained to an investigation into an alleged incident of staff to resident abuse that had occurred on a specified date. The interview notes were dated six days after the incident occurred. The package also included an email that was addressed to the Executive Director, dated four days after the incident occurred. The email was written by PSW #101 and it indicated that they had observed PSW #134 with resident #022. The resident was stating repeatedly that they were in pain. PSW #101 observed PSW #134 put resident #022 into their bed in a rough manner. Resident #022 was then observed to reach for a glass of water that was at the bedside, and proceed to throw the water at PSW #134. PSW #134 then left the resident room and once in the hallway, the PSW made a comment to PSW #101 about resident #022. RN #106 was nearby and overheard the incident. PSW #101 indicated that the RN laughed about what had occurred and did not treat the incident as abuse.

On a specific date and time, during an interview with Inspector #623, the ED indicated that they were uncertain if the SDM for resident #022 was ever notified of the alleged incident that occurred on a specified date.

During a telephone interview with Inspector #623, the former DOC indicated there was an incident that had occurred on a specified date, involving resident #022, that was immediately reported to the RN's. The DOC indicated that at the time of the incident the RN's did not take further action to investigate the allegation of abuse. The former DOC indicated that an email was submitted to the ED three days later by PSW #101 who witnessed the incident. The PSW indicated that they had been made aware that nothing had become of their initial report to the RN's and were informing the ED of the incident. The former DOC indicated that there was no CIR submitted for the incident but an investigation was conducted. The former DOC indicated that the SDM for resident #022 was not notified of the allegation of abuse by PSW #134.

The licensee failed to ensure that resident #022's SDM and any other person specified by the resident, were notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident. [s. 97. (1) (b)]

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 by ensuring that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident, to be implemented voluntarily.

Issued on this 13th day of June, 2019

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

Original report signed by the inspector.