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
May 10, 2019	2019_505103_0014	025453-18, 005934-19, 007602-19	Critical Incident System

Licensee/Titulaire de permis

Crown Ridge Health Care Services Inc.
106 Crown Street TRENTON ON K8V 6R3

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

Crown Ridge Place
106 Crown Street TRENTON ON K8V 6R3

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

DARLENE MURPHY (103)

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): April 30, May 1-3, 2019.

Log #025453-18 (CIS #2787-000014-18) and Log #005934-19 (CIS #2787-000004-19)-alleged incidents of resident to resident physical abuse,
Log #007602-19 (CIS #2787-000005-19)-alleged incident of resident to resident sexual abuse.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Assistant Director of Care (ADOC), the Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector reviewed resident health care records, the critical incident reports submitted by the home, and the home's abuse policy, "Abuse/Neglect or Suspected Abuse/Neglect of a Resident-ADM 7.0".

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 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	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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

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

Sexual abuse is defined by O. Reg 79/10, s. 2 (1) as any non-consensual touching, behavior or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

On an identified date, the home submitted a critical incident report (CIR) #2787-000005-19 to report an incident of resident sexual abuse involving residents #003 and #004. The CIR indicated resident #004 had been observed by PSW #101 inappropriately touching resident #003 and that resident #003 reacted by yelling out.

PSW #101 was interviewed and indicated they were in the hallway and heard resident #003 yelling. PSW #101 stated when they looked over they saw resident #004 standing close to resident #003 and resident #004 was inappropriately touching resident #003. PSW #101 stated they immediately separated the residents. PSW #101 stated they noted resident #003 had tears in their eyes and appeared to be upset. PSW #101 provided emotional support to resident #003 and reported the incident to RPN #100 at that time. PSW #101 further stated the resident remained upset for a period of time following the incident and required ongoing support and distraction before they calmed down.

RPN #100 was interviewed and recalled they had been notified of the incident by PSW #101. RPN #100 indicated they were aware the touching was inappropriate and believed it constituted an incident of sexual abuse, but failed to report the incident to the charge nurse at that time. RPN #100 stated they ensured residents #003 and #004 were kept separated that evening to avoid another incident. RPN #100 indicated they had never encountered a previous, similar incident and was unsure of the reporting obligations. The home's abuse policy, "Abuse/Neglect or Suspected Abuse/Neglect of a Resident-ADM 7.0" indicates all employees shall immediately notify the Charge Nurse of a suspected or actual abuse.

Resident #003's Power of attorney (POA) was notified for the first time of the alleged incident of abuse the following day. According to PSW #101, resident #003 was upset, had tears in their eyes and remained upset for a period of time following the incident. The home's abuse policy, "Abuse/Neglect or Suspected Abuse/Neglect of a Resident-ADM 7.0" indicates the resident's substitute decision maker will be immediately notified of any alleged, suspected or witnessed incident of abuse or neglect that resulted in a physical

injury, pain or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being.

DOC #107 was interviewed and indicated they were not working when the incident occurred and became aware of the incident when reviewing the twenty-four hour notes upon their return to work four days later. DOC #107 stated resident #004's POA was notified of the alleged abuse for the first time on that identified date. The home's abuse policy, "Abuse/Neglect or Suspected Abuse/Neglect of a Resident-ADM 7.0" indicates the resident's substitute decision maker will be notified within twelve hours of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Additionally, DOC #107 reported the police were notified for the first time of the alleged incident of abuse on an identified date. The home's abuse policy, "Abuse/Neglect or Suspected Abuse/Neglect of a Resident-ADM 7.0" indicates the appropriate police force will be immediately notified of any alleged, suspected or witnessed incident of abuse or neglect that the licensee suspects may constitute a criminal offence.

The home failed to comply with the abuse policy "Abuse/Neglect or Suspected Abuse/Neglect of a Resident-ADM 7.0". [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 the home's abuse policy, "Abuse/Neglect or Suspected Abuse/Neglect of a Resident-ADM 7.0", was 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. A person who had reasonable grounds to suspect resident #003 had been sexually abused by resident #004, failed to report the suspicion and the information upon which it was based immediately to the Director.

As outlined in WN #1, an incident of resident sexual abuse involving residents #003 and #004 occurred on an identified date.

RPN #100 was interviewed and indicated they were aware the touching was inappropriate and believed it constituted an incident of sexual abuse, but failed to report the incident to the charge nurse at that time.

DOC #107 was interviewed and indicated they became aware of the incident four days following the incident. DOC #107 indicated the CIR was submitted to the Ministry of Health and Long-Term Care (MOHLTC) at that time and provided to this inspector the home's actions in response to the late reporting of the alleged sexual abuse. [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 a person who has reasonable grounds to suspect the abuse of a resident by anyone that resulted in harm or a risk of harm to the resident immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #3: 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 the resident's substitute decision maker was immediately notified of an alleged, suspected or witnessed incident of abuse of a resident that caused distress to resident #003 that could potentially be detrimental to the resident's health or well-being.

As outlined in WN #1, resident #003 was observed yelling out in response to being touched by resident #004. PSW #101 reported the resident had tears in their eyes and required emotional support and distraction following the incident before resident #003 settled. Upon review of the resident's health care record, it was determined resident #003's power of attorney (POA) were notified for the first time the following day, not immediately as outlined in the legislation.

Additionally, resident #004's POA was notified four days after the incident. [s. 97. (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 the resident's substitute decision maker is immediately notified of all alleged, suspected or witnessed incidents of resident abuse that cause distress to the resident or that could potentially be detrimental to the resident's health or well-being and are notified within twelve hours upon the licensee becoming aware of any other alleged, suspected or witnessed incidents of abuse or neglect of the resident, 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 the appropriate police force were immediately notified of the alleged, suspected or witnessed incident of resident abuse that the home suspected may have constituted a criminal offence.

As outlined in WN #1, an incident involving resident #003 and resident #004 occurred on an identified. In an interview with DOC #107, they indicated the incident should have been immediately reported to the police. DOC #107 stated the police were notified four days following the incident. [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 the appropriate police force is immediately notified of all alleged, suspected or witnessed incidents of resident abuse that the home suspect may constitute a criminal offence, to be implemented voluntarily.

Issued on this 15th day of May, 2019

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

Original report signed by the inspector.