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
May 23, 2018	2018_725522_0004	031543-16, 002514-17	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the City of London
355 Wellington St, 2nd Floor, Suit 248 LONDON ON N6A 3N7

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

Dearness Home for Senior Citizens
710 Southdale Road East LONDON ON N6E 1R8

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

JULIE LAMPMAN (522)

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 19, 20 and 23, 2018.

The following critical incidents were inspected concurrently during this inspection:
Critical Incident System report #M514-000057-16/Log #031543-16 related to allegations of abuse.
Critical Incident System report #M514-000002-17/Log #002514-17 related to allegations of abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, two Assistant Directors of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, a Housekeeping Aide, a Staffing Scheduler and residents.

During the course of the inspection, the inspector observed staff and resident interactions, reviewed resident clinical records, investigative notes and relevant policies and procedures.

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.
- **3 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 has failed to ensure that the written policy to promote zero tolerance of

abuse and neglect of residents was complied with.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care. The CIS report indicated that a resident reported to the registered nurse (RN) in charge that they were worried that a Personal Support Worker (PSW) may have abused a resident.

In a telephone interview, the RN stated they emailed the concern regarding the alleged abuse to the previous Director of Care (DOC) and Assistant Directors of Care (ADOCs) the day it was reported to them.

A review of the home's investigative notes noted an email to the previous DOC and ADOCs from the RN regarding the concern from the resident regarding alleged abuse of another resident.

A review of Dearness Home policy Resident Abuse - Staff to Resident revised/reviewed March 2013, indicated that upon notification of suspected or witnessed abuse, the Administrator/Director of Care/Designate will "Immediately remove the employee from the work schedule, with pay, pending investigation."

In an interview, the Staffing Scheduler reviewed the PSW's schedule and stated that the PSW had worked after the abuse was reported to management.

In an interview the Assistant Director of Care (ADOC) reviewed the PSW's schedule and confirmed that the PSW was called in to fill a shift and did work after the allegations of abuse were made against the PSW. The ADOC stated they were aware of the allegations of abuse and that initially the PSW was not scheduled to work, and the ADOC and Human Resources had planned to meet with the PSW at the beginning of their next shift to discuss the allegations. The ADOC stated that although the PSW should not have worked, the PSW had been called in for a shift. The ADOC stated that the staffing scheduler must not have been notified that the PSW was to be removed from the schedule pending the investigation.

In an interview, the Administrator stated for any allegations of abuse, before the home would start an investigation, in order to do their due diligence they would remove the accused staff member from work. The Administrator stated the PSW should not have been called into work after the allegations of abuse were made.

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with. [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 the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: 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 has 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 suspected may constitute a criminal offence.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Health and Long-Term Care. The CIS report indicated that a resident reported to the registered nurse (RN) in charge that they were worried that a Personal Support Worker (PSW) may have abused a resident.

In a telephone interview, the RN stated they emailed the concern regarding the alleged abuse to the previous Director of Care (DOC) and Assistant Directors of Care (ADOCs) the day it was reported to them.

A review of Dearness Home policy Resident Abuse - Staff to Resident revised/reviewed March 2013, indicated that upon notification of suspected or witnessed abuse, the Administrator/Director of Care/Designate will "If circumstances are unsafe, contact police immediately or if a criminal offence has taken place (e.g. theft, sexual or physical abuse assault).

A review of the CIS indicated “Police will be contacted.”

A review of the home’s investigative notes did not contain the date the police were notified, the name of the police officer responding to the incident or incident number.

In an interview, the ADOC indicated that the previous Director of Care had not contacted police as indicated in the CIS report. The ADOC indicated that once the investigation was completed, it was determined that the allegations were unfounded and therefore the police were not called.

In an interview, the Administrator stated that police should have been notified immediately of the alleged abuse.

The licensee has 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 suspected may constitute a criminal offence. [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 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following actions taken in response to the incident: What other authorities were contacted about the incident, if any."

A review of a CIS report submitted by the home to the Ministry of Health and Long-Term Care indicated "Police will be contacted."

The CIS report had not been amended to reflect that the home had not contacted the police.

In an interview, the ADOC indicated the CIS should have been updated to reflect that the police were not notified.

In an interview, the Administrator stated the CIS report should have been updated.

The licensee has failed to ensure that the report to the Director included the authorities who were contacted in response to the incident, if any. [s. 104. (1) 3.]

Issued on this 25th day of June, 2018

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

Original report signed by the inspector.