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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 11, 2018	2018_577611_0019	006675-18	Complaint

Licensee/Titulaire de permis

The Regional Municipality of Niagara
1815 Sir Isaac Brock Way THOROLD ON L2V 4T7

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

Douglas H. Rapelje Lodge
277 Plymouth Road WELLAND ON L3B 6E3

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

KELLY CHUCKRY (611)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 26, 29, 30, 31, November 1, 2, 7, 8, and December 5, 2018.

This Complaint inspection was conducted concurrently with a Critical Incident inspection. This complaint inspection includes the following intakes:

Log 006882-18 pertaining to Personal Support Services, Skin and Wound Care, and the
Prevention of Abuse and Neglect
Log 027634-18 pertaining to the Prevention of Abuse and Neglect
Log 021420-18 pertaining to the Prevention of Abuse and Neglect
Log 024580-18 pertaining to the Prevention of Abuse and Neglect
Log 009862-18 pertaining to the Prevention of Abuse and Neglect

The Critical Incident inspection has been captured in report #2018_577611_0018 / 006882-18, 009862-18, 021420-18, 024496-18, 024580-18, 027634-18

During the course of the inspection, the inspector(s) spoke with the Administrator, Associate Director of Resident Care (ADRC), Programs Manager, Clinical Documentation and Information Coordinator (CDI Coordinator), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and families.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from abuse by anyone.

For the purposes of the definition of "abuse" in subsection 2(1) of the Long-Term Care homes Act, 2007,
"sexual abuse" means, subject to subsection (3),

a) 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

b) 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; ("mauvais traitement d'ordre sexuel")

A review of a Critical Incident (CI) report #M604-000027-18 described an incident that occurred between resident #001 and resident #002. A further review of the clinical health records and the homes investigation notes took place with respect to this incident.

This incident occurred in September 2018, and was witnessed. The individual did not report the incident until an identified number of days after the incident, at which time it was reported to registered staff #108. Registered staff #108 did not document, or report the incident to anyone else in the home. The individual reported the incident a second time, to registered staff #109, an identified number of days after the incident.

In an interview conducted with registered staff #108 in December 2018, this staff member indicated the incident was reported to them an identified number of days after the incident. They further indicated that the individual was directed to speak with the DRC about the incident, and acknowledged that the incident was a form of abuse.

The plan of care for resident #002, initiated in May 2018, identified that this resident exhibited a responsive behaviour, either verbal or physical towards residents.

Resident #001 had a Cognitive Performance Scale (CPS) score indicating that they could not provide consent.

In an interview conducted with the administrator in November 2018, it was confirmed that

the incident took place, and registered staff #108 was disciplined as a result of not responding appropriately to the abuse reported to them. It was further confirmed by the ADOC and the Administrator, that resident #001 was not protected from abuse from resident #002. [s. 19. (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 all residents are protected from abuse by anyone, to be implemented voluntarily.

WN #2: 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 there was a written policy that promoted zero tolerance of abuse and neglect of residents and that it was complied with.

A review of a Critical Incident (CI) report #M604-000027-18 described an incident that occurred between resident #001 and resident #002. A further review of the clinical health records and the homes investigation notes took place with respect to this incident.

This incident occurred in September 2018, and was witnessed. The individual did not report the incident until an identified number of days after the incident, at which time it was reported to registered staff #108. Registered staff #108 did not document, or report the incident to anyone else in the home. The individual reported the incident a second time, to registered staff #109, an identified number of days after the incident.

The home had a policy entitled "Abuse and Neglect-Zero Tolerance" (RR00-001) with a revision date of August 2018. The procedure for reporting and investigating abuse and neglect was outlined in the policy as follows:

-The Registered staff will perform a complete assessment of the resident and document the assessment findings in the resident's progress notes as necessary.
-A report of an alleged, witnessed, or suspected incident of abuse or neglect must be reported to the Director of Resident Care, Administrator, or designate immediately.
-Document a factual note to record the allegations made. Record only facts and leave out personal judgement or opinions. For example, use "resident states.....". Be mindful that the word inappropriate is a judgement/opinion and not a fact. Document the words states and/or the actions witnessed, and avoid making a summary based on opinion.
The home will immediately start the investigation of the incident.

The above noted points in the procedure for reporting and investigating incidences of abuse were not complied with by registered staff #108, when the incident was reported to them an identified number of days after the incident. In a letter dated October 2018 to registered staff #108, they were disciplined for failing to follow the Abuse and Neglect-Zero Tolerance Policy.

In an interview conducted with registered staff #108 in December 2018, this staff member indicated the incident was reported to them an identified number of days after the incident. They further indicated that the individual was directed to speak with the DRC about the incident, and acknowledged that the incident was a form of abuse.

In an interview conducted with the ADOC in November 2018, and a subsequent discussion with the Administrator, it was acknowledged that registered staff #108 did not comply with the homes zero tolerance of abuse and neglect policy. [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 there is a written policy that promotes zero tolerance of abuse and neglect of residents and that is is complied with, to be implemented voluntarily.

WN #3: 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 when a person had reasonable grounds to suspect that any of the following had occurred or may have occurred, shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

For the purposes of the definition of "abuse" in subsection 2(1) of the Long-Term Care homes Act, 2007,

"sexual abuse" means, subject to subsection (3),

a) 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

b) 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; ("mauvais traitement d'ordre sexuel")

A review of a Critical Incident (CI) report #M604-000027-18 described an incident that occurred between resident #001 and resident #002. A further review of the clinical health records and the homes investigation notes took place with respect to this incident.

This incident occurred in September 2018, and was witnessed by an individual who was in the home at the time. The individual did not report the incident until an identified number of days after the incident, at which time it was reported to registered staff #108. Registered staff #108 did not document, or report the incident to anyone else in the home. The individual reported the incident a second time, to registered staff #109, an identified number of days after the incident, at which time it was immediately reported to the Director.

In an interview conducted with registered staff #108 in December 2018, this staff member indicated the incident was reported to them an identified number of days after the incident. They further indicated that the individual was directed to speak with the DRC about the incident, and acknowledged that the incident was a form of abuse. Registered staff #108 confirmed this incident of abuse was not reported to the Director immediately upon them becoming aware of the incident.

The plan of care for resident #002, initiated in May 2018, identified that this resident exhibited responsive behaviours, either verbal or physical towards residents.

Resident #001 had a Cognitive Performance Scale (CPS) score of five out of six indicating that they could not provide consent.

In an interview conducted with the administrator in November 2018, it was confirmed that the incident took place, and registered staff #108 was disciplined as a result of not responding appropriately to the abuse reported to them. It was further confirmed by the

ADOC and the Administrator, that this incident was not 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 to ensure that when a person 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:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, to be implemented voluntarily.

Issued on this 8th day of January, 2019

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

Original report signed by the inspector.