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
May 2, 2019	2019_617148_0010	003936-19, 004009-19, 004282-19, 006068-19	Critical Incident System

Licensee/Titulaire de permis

Dundas Manor Limited
533 Clarence Street P.O. Box 970 WINCHESTER ON K0C 2K0

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

Dundas Manor Nursing Home
533 Clarence Street P.O. Box 970 WINCHESTER ON K0C 2K0

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

AMANDA NIXON (148), JESSICA LAPENSEE (133), MARK MCGILL (733)

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 10, 11, 12, 15 and 16, 2019

This inspection included four critical incident reports (CIR): CIR #2674-000003-19 (Log 003936-19); CIR #2674-000005-19 (Log 004009-19); CIR #2674-000006-19 (Log 004282-19); and CIR #2674-000008-19 (Log 006068-19).

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Maintenance Supervisor, Corporate Manager of Building and Support Services, Scheduler, Registered Practical Nurses, Registered Nurses, Personal Support Workers and residents.

The Inspectors also reviewed resident health care records, documentation related to mandatory staff training, relevant documentation related to the licensee's investigations into alleged abuse and neglect and the licensee's policy to promote zero tolerance of abuse and neglect. In addition, observations were made of the hot water heaters and hot water holding tank along with resident's environment and staff to resident interaction.

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

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **0 VPC(s)**
- **2 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 :

The licensee has failed to ensure that resident #003 was protected from neglect.

In accordance with section 5 of O. Regulation 79/10, neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The DOC submitted a critical incident report to the Director, describing that PSW #107 reported to a charge nurse on duty and by email to senior management, information related to the alleged neglect of resident #003.

Inspector #148 spoke with PSW #107 regarding the two incidents. With regards to the first incident, PSW #107 described that on a specified date, that the PSW entered the room of resident #003, between 2200-2230 hours, to assist PSW #114 with care as the resident had been incontinent of bowel. PSW #107 described that the resident was heavily soiled with stool on the soaker pad and with areas of hardened stool on both the resident and soaker pad. Resident #003 reported to both PSWs that earlier during the evening shift, the resident had called for assistance to be toileted to which an unidentified evening staff member responded and that they were too busy at the time to assist resident #003 and would be back later. Resident #003 reported that staff never returned to provide assistance. PSW #107 noted resident #003 was apologetic for taking up the staff's time and for being a bother; PSW attempted to provide comfort. PSW #107 believed that this incident was alleged neglect and after providing care to resident #003, reported the incident to the evening charge RN #108. PSW #107 reported that RN took no action. After the RN shift change at 2300 hours, PSW #107 reported the same information to the night charge RN #113, who indicated that the incident occurred on the shift of RN #108 and since the PSW had already reported it to RN #108 no action was required by RN #113. PSW #107, in partnership with PSW #114, wrote an email to the ADOC and DOC the next day, describing the incident of alleged neglect that occurred the evening before. With regards to the second incident, PSW #107 reported that at approximately 2230 hours, 15 days after the initial incident, the resident had rang for assistance and PSW #107 and PSW #114 responded. Resident #003 reported that the resident had requested to use the commode earlier during the evening shift and was told by an evening staff member to urinate in the brief. The resident further indicated that the same staff member returned to check the brief and said that the resident had not wet and that the PSW refused to change the brief. The resident reported that the evening PSW was annoyed with resident #003 and resident #003 felt like a bother. PSW #107 provided comfort and attempted to probe the resident for the evening PSW's identity; the resident identified PSW #103. PSW #107 reported the alleged neglect to RPN #115 who advised

PSW #107 to speak with charge RN #109. PSW #107 than reported the alleged neglect to RN #109, who advised the PSW to write an email to the management team. PSW #107, in partnership with PSW #114, wrote an email to the ADOC, DOC and Administrator during the same night shift, describing the incident of alleged neglect with note in the opening statement of the email sent 14 days earlier.

RN #108, indicated in an email to the DOC that although the RN may have received information related to continence care from PSW #107, there was no information of any concern suggesting abuse or neglect. In an interview with RN #109, the RN reported that the RN recalled PSW #107 reporting that the resident was told by an evening PSW to urinate in the incontinence product. RN #109 indicated that the identified evening PSW had already left the building and since the report was alleged neglect and could not be confirmed, no further actions were taken by the RN. RN #109 reported that the RN intended to bring the information forward during the next scheduled shift; the schedule indicated that the RN's next shift was three days after PSW #107's report.

In an interview with the ADOC, it was reported that the ADOC received the email first email from PSW #107, four days after it was sent. The ADOC reported that an assumption was made that the DOC, who was also addressed on the email, had taken action on the contents of the email. The ADOC indicated that the second email from by PSW #107, was likely received by the ADOC three to four days after it was sent. In discussion, the ADOC believed that there was reasonable grounds in both emails to suspect neglect of a resident by a staff member.

In an interview with the DOC, it was reported that the first email from PSW #107 was not read until 20 days after. The DOC acknowledged that the email was likely inadvertently marked as read and therefore did not get actioned on the date it was received. The DOC confirmed that the second email from PSW #107 was not received until four days after it was sent, at the time of the DOC's next scheduled work day. The DOC indicated that the concerns in both emails were brought to her attention 20 days after the first email, by the home's Administrator. In discussion, the DOC believed that there was reasonable grounds in both emails to suspect neglect of a resident by a staff member.

In an interview with the Administrator, it was reported that the Administrator reviewed the second email sent by PSW #107 on the same day it was sent. The Administrator noted that it was not until the investigation was initiated, that the Administrator was aware that there were two incidents of alleged neglect. In discussion, the Administrator believed that there was reasonable grounds in both emails to suspect resident neglect. When

asked, the Administrator reported action was initiated three days after the second email was received as the Administrator wished to discuss the matter further with the DOC. Three days after receiving the second email, the Administrator initiated an investigation by speaking with RN #109.

Four days after the second email, the DOC took the lead and continued the investigation. The DOC reported that the investigation included interviews with RN #109, PSW #103, PSW #116, PSW #107 and the resident. In addition, on the same day, PSW #103 was placed on leave pending the investigation; the schedule indicated that PSW #103 worked ten shifts during the specified period of time. Five days after the second email, the DOC notified the Director (Ministry of Health and Long Term Care) of the alleged neglect.

Six days after the second email, PSW #103 was provided a letter, written by the DOC, which indicated that the investigation was inconclusive but that the complaints were concerning. PSW #103 was provided the letter by the Administrator on the same date and PSW #103 was asked to complete re-training by reviewing, signing and returning four documents along with a viewing the Abuse Prevention One is One Too Many video. The PSW was to have completed this training within the next three days. The Administrator noted that the intent was for the staff member to complete such additional training prior to their return to work. The Inspector noted that PSW #103 returned to work the next day having not completed all of the training; record indicated that the video had been reviewed two days after the letter was issued. The Inspector spoke with the DOC, regarding the required training described by the letter to PSW #103. The DOC reported that the intent was for such training to be completed prior to a staff members return to work. The DOC could not confirm if the documents had been reviewed prior to the PSW's return to work.

In addition, the licensee has failed to ensure:
1- That the policy to promote zero tolerance of abuse and neglect is compliant with s. 20(2) of the LTCHA, 2007, specifically related to neglect (see WN #3);
2- That all staff were provided with training on the required contents of the policy to promote zero tolerance of abuse and neglect of residents (see WN #2 and CO #002);
3- That the licensee immediately investigated and took appropriate action in response to an incident of alleged neglect (see WN #4); and
4- That the Director was notified immediately of reasonable grounds to suspect neglect of a resident by the staff member (see WN #5).

(Log 001213-19)

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

The licensee failed to ensure that that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

In accordance with section 76 (1) and (2) of the LTCHA, 2007 and section 219 (1) of O. Regulation 79/10, all staff are to receive training in the long-term care home's policy to promote zero tolerance of abuse and neglect of residents and that staff will be provided such training at annual intervals. The required contents of the home's policy to promote zero tolerance of abuse and neglect of residents is described in section 20 (2) of the LTCHA, 2007 and section s.96 of O. Regulation 79/10.

As described by WN #1, related to section 19 of the LTCHA, 2007, a critical incident report was submitted to the Director describing the alleged neglect of resident #003. It was demonstrated that several staff had information that would have been reasonable grounds to suspect neglect, however, action to protect the resident was delayed.

The lead for education in the home, was identified as the ADOC, who reported that all staff in the home are required to compete annual mandatory training on the policy to promote zero tolerance of abuse and neglect of residents. The ADOC identified six online courses that are to be completed by all staff as the training on the policy to promote zero

tolerance of abuse and neglect of residents.
The following were the online courses identified:
1- Abuse Prevention One is One too Many Part 2
2- Abuse Prevention One is One too Many Part 5
3- Critical Incidents Part 1: Categories and Timelines for Reporting
4- Critical Incidents Part 2: Mandatory Reporting Responsibilities and Procedures
5- Critical Incidents Part 3: Whistle Blowing Protection
6- Legislated Required Programs

The Inspector reviewed the training record of RN #109, RPN#113, RN #115 and PSW #103 who had completed the six required courses within the 2018 calendar year. In review of the training record for RN #108 and PSW #107, four to five courses had not been completed including the three courses titled Critical Incidents, to which mandatory reporting was discussed.

The Inspector reviewed the above six identified courses and found that the training lacks in the following required areas:
- provide that abuse and neglect are not to be tolerated;
- clearly set out what constitutes abuse and neglect;
- contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
- shall set out the consequences for those who abuse or neglect residents;
- procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
- procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
- measures and strategies to prevent abuse and neglect;
- the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation;
- the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care; and
- situations that may lead to abuse and neglect and how to avoid such situations.

Additional non-compliance was identified related to s. 20 of the LTCHA, 2007 (see WN #3). As indicated, the licensee's policy to promote zero tolerance of abuse and neglect of residents was lacking in content related specifically to neglect.

(Log 001213-19)

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents contains the requirements of section 20 (2).

As described by WN #1, related to section 19 of the LTCHA, 2007, a critical incident report was submitted to the Director describing the alleged neglect of resident #003.

The home's DOC identified policy #ADM-04-004, titled Prevention of Abuse and Neglect – Resident Abuse Policy, as the home's policy to promote zero tolerance of abuse and neglect of residents.

The policy described the following:
- All staff who witness or suspect the abuse of a resident are required to report the matter immediately to their supervisor, the Charge Nurse, Director of Care or the Administrator;
- All staff are required to immediately report alleged/apparent abusive acts that they have witnessed or become aware of;
- Staff members found to have committed abusive acts will be subject to disciplinary action;
- Any staff witnessing or having knowledge of an alleged actual act of abuse shall immediately report it to his/her immediate Manager, the Director of Care or the Administrator;
- Upon becoming informed of an alleged act of abuse the Supervisor/Manager will immediately inform the Administrator or Designate; and
- Reporting Abuse:
o Registered nursing staff/DOC shall document a detailed description of the incident in the resident's record
o An investigation shall be commenced immediately
o Suspected staff member shall be relieved of their duties while investigation is being conducted
o Manager shall investigate all incidents

The contents of the policy do not reflect actions that are to be taken when a person suspects neglect has occurred or may occur. Procedures within the policy speak to that related to abuse and in this way the policy does not contain the requirements as set out by s. 20 (2) (c). (e) and (f).

(Log 001213-19)

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

The licensee has failed to ensure that every alleged, suspected or witnessed incident of neglect of a resident by staff, that the licensee knows of, or that is reported to the licensee, is immediately investigated and that appropriate action is taken in response to every such incident.

As described by WN #1, related to section 19 of the LTCHA, 2007, a critical incident report was submitted to the Director describing the alleged neglect of resident #003.

The findings of WN #1 demonstrate that supervisory staff members had reasonable grounds to suspect that neglect of a resident had occurred on two identified dates. In addition, managers were reported information on two identified dates.

The licensee's investigation was initiated on 20 days after the first incident and 15 days after a member of the management team acknowledges having information related to suspected neglect. PSW #103 continued to provide care to residents during the specified time period whereby a second incident occurred. The training required to be provided to PSW #103 was not completed as intended prior to the PSW's return to work.

In this way, the licensee did not immediately investigate or take appropriate action in response to resident neglect that was reported to the licensee.

(Log 001213-19)

WN #5: 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 :

The licensee has failed to ensure that a person who has reasonable grounds to suspect that neglect of a resident by staff that resulted in harm or a risk of harm to the resident, has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

As described by WN #1, related to section 19 of the LTCHA, 2007, a critical incident report was submitted to the Director describing the alleged neglect of resident #003.

The findings of WN #1 demonstrate that two direct care staff members, along with supervisory staff members had reasonable grounds to suspect that neglect of a resident had occurred on two specified dates. In addition, managers were reported information on two specified dates.

The Director was informed of the alleged neglect 22 days after the initial incident, when a critical incident report was submitted by the DOC. In this way the Director was not informed immediately of suspected neglect of a resident.

(Log 001213-19)

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented to ensure that hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service.

As reported in a critical incident report, there was a loss of domestic hot water on the afternoon of March 17, 2019. On April 10, 2019, the Maintenance Supervisor (MS) indicated to Inspector #133 that a blower failure was the cause of the malfunction, and that the domestic hot water heater was repaired the afternoon of March 18, 2019. The MS indicated that there was a second hot water heater, which served the kitchen exclusively.

Over the course of the inspection, in collaboration with the MS and the Manager of Building Services, it was determined that there was no procedure developed to ensure that the hot water heaters are serviced at least annually. As well, it was determined that there was no such procedure in place with regards to the hot water holding tank, which is connected to the domestic hot water heater. [s. 90. (2) (f)]

WN #7: 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 :

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 suspects may constitute a criminal offence.

On a specified date, the Director was informed of an alleged staff to resident physical abuse.

In an interview with Inspector #733, resident #001 described the events that took place during the incident. The resident indicated that PSW #104 became angry after resident #001 requested that another staff provide their care and PSW #104 pushed them backwards in their wheelchair.

A review of the homes investigation file produced photographs of bruising from the incident. Taking this and other factors including multiple interviews with resident #001, the home took the action of terminating PSW #104's employment.

In an interview with Inspector #733 on April 11, 2019, the Director of Care indicated that the police were not notified as resident #001 was adamant that they not be contacted.

Therefore, the licensee failed to contact police when it was suspected that the incident may have constituted a criminal offence.

(Log 003936-19)

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*

Issued on this 21st day of May, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMANDA NIXON (148), JESSICA LAPENSEE (133), MARK MCGILL (733)
Inspection No. / No de l'inspection :	2019_617148_0010
Log No. / No de registre :	003936-19, 004009-19, 004282-19, 006068-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 2, 2019
Licensee / Titulaire de permis :	Dundas Manor Limited 533 Clarence Street, P.O. Box 970, WINCHESTER, ON, K0C-2K0
LTC Home / Foyer de SLD :	Dundas Manor Nursing Home 533 Clarence Street, P.O. Box 970, WINCHESTER, ON, K0C-2K0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Susan Poirier

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To Dundas Manor Limited, you are hereby required to comply with the following order (s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with LTCHA, 2007, s.19

Specifically the licensee shall:
Develop a plan to ensure residents are protected from neglect.

The plan shall include, but is not limited to:
1) Procedures for communication and collaboration between direct care staff, supervisory staff and senior management; and
2) Procedures to ensure that every alleged, suspected or witnessed incident of abuse and/or neglect that is reported to the licensee, is immediately investigated and appropriate actions are taken.

The plan shall be documented.

This plan must be submitted in writing by May 17, 2016, to Amanda Nixon, LTCH Inspector at 347 Preston St., 4th floor, Ottawa ON K1S 3J4 OR by fax at 1 -613-569-9670.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #003 was protected from neglect.

In accordance with section 5 of O. Regulation 79/10, neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The DOC submitted a critical incident report to the Director, describing that PSW #107 reported to a charge nurse on duty and by email to senior management, information related to the alleged neglect of resident #003.

Inspector #148 spoke with PSW #107 regarding the two incidents. With regards to the first incident, PSW #107 described that on a specified date, the PSW entered the room of resident #003, between 2200-2230 hours, to assist PSW #114 with care as the resident had been incontinent of bowel. PSW #107 described that the resident was heavily soiled with stool on the soaker pad and with areas of hardened stool on both the resident and soaker pad. Resident #003 reported to both PSWs that earlier during the evening shift, the resident had called for assistance to be toileted to which an unidentified evening staff member responded and that they were too busy at the time to assist resident #003 and would be back later. Resident #003 reported that staff never returned to provide assistance. PSW #107 noted resident #003 was apologetic for taking up the staff's time and for being a bother; PSW attempted to provide comfort. PSW #107 believed that this incident was alleged neglect and after providing care to resident #003, reported the incident to the evening charge RN #108. PSW #107 reported that RN took no action. After the RN shift change at 2300 hours, PSW #107 reported the same information to the night charge RN #113, who indicated that the incident occurred on the shift of RN #108 and since the PSW had already reported it to RN #108 no action was required by RN #113. PSW #107, in partnership with PSW #114, wrote an email to the ADOC and DOC the next day, describing the incident of alleged neglect that occurred the evening before. With regards to the second incident, PSW #107 reported that at approximately 2230 hours, 15 days after the initial incident, the resident had rang for assistance and PSW #107 and PSW #114 responded. Resident #003 reported that the resident had requested to use the commode earlier during the evening shift and was told by an evening staff member to urinate in the brief. The resident further indicated that the same staff member returned to check the brief and said that the resident had not wet and that the PSW refused to change the brief. The resident reported that the evening PSW was annoyed with resident #003 and resident #003 felt like a bother. PSW #107 provided comfort and attempted to probe the resident for the evening PSW's identity; the resident identified PSW #103. PSW #107 reported the alleged neglect to RPN #115 who advised PSW #107 to speak with charge RN #109. PSW #107 than reported the alleged neglect to RN #109, who advised the PSW to write an email to the

management team. PSW #107, in partnership with PSW #114, wrote an email to the ADOC, DOC and Administrator during the same night shift, describing the incident of alleged neglect with note in the opening statement of the email sent 14 days earlier.

RN #108, indicated in an email to the DOC that although the RN may have received information related to continence care from PSW #107, there was no information of any concern suggesting abuse or neglect. In an interview with RN #109, the RN reported that the RN recalled PSW #107 reporting that the resident was told by an evening PSW to urinate in the incontinence product. RN #109 indicated that the identified evening PSW had already left the building and since the report was alleged neglect and could not be confirmed, no further actions were taken by the RN. RN #109 reported that the RN intended to bring the information forward during the next scheduled shift; the schedule indicated that the RN's next shift was three days after PSW #107's report.

In an interview with the ADOC, it was reported that the ADOC received the email first email from PSW #107, four days after it was sent. The ADOC reported that an assumption was made that the DOC, who was also addressed on the email, had taken action on the contents of the email. The ADOC indicated that the second email from by PSW #107, was likely received by the ADOC three to four days after it was sent. In discussion, the ADOC believed that there was reasonable grounds in both emails to suspect neglect of a resident by a staff member.

In an interview with the DOC, it was reported that the first email from PSW #107 was not read until 20 days after. The DOC acknowledged that the email was likely inadvertently marked as read and therefore did not get actioned on the date it was received. The DOC confirmed that the second email from PSW #107 was not received until four days after it was sent, at the time of the DOC's next scheduled work day. The DOC indicated that the concerns in both emails were brought to her attention 20 days after the first email, by the home's Administrator. In discussion, the DOC believed that there was reasonable grounds in both emails to suspect neglect of a resident by a staff member.

In an interview with the Administrator, it was reported that the Administrator reviewed the second email sent by PSW #107 on the same day it was sent. The

Administrator noted that it was not until the investigation was initiated, that the Administrator was aware that there were two incidents of alleged neglect. In discussion, the Administrator believed that there was reasonable grounds in both emails to suspect resident neglect. When asked, the Administrator reported action was initiated three days after the second email was received as the Administrator wished to discuss the matter further with the DOC. Three days after receiving the second email, the Administrator initiated an investigation by speaking with RN #109.

Four days after the second email, the DOC took the lead and continued the investigation. The DOC reported that the investigation included interviews with RN #109, PSW #103, PSW #116, PSW #107 and the resident. In addition, on the same day, PSW #103 was placed on leave pending the investigation; the schedule indicated that PSW #103 worked ten shifts during the specified period of time. Five days after the second email, the DOC notified the Director (Ministry of Health and Long Term Care) of the alleged neglect.

Six days after the second email, PSW #103 was provided a letter, written by the DOC, which indicated that the investigation was inconclusive but that the complaints were concerning. PSW #103 was provided the letter by the Administrator on the same date and PSW #103 was asked to complete re-training by reviewing, signing and returning four documents along with a viewing the Abuse Prevention One is One Too Many video. The PSW was to have completed this training within the next three days. The Administrator noted that the intent was for the staff member to complete such additional training prior to their return to work. The Inspector noted that PSW #103 returned to work the next day having not completed all of the training; record indicated that the video had been reviewed two days after the letter was issued. The Inspector spoke with the DOC, regarding the required training described by the letter to PSW #103. The DOC reported that the intent was for such training to be completed prior to a staff members return to work. The DOC could not confirm if the documents had been reviewed prior to the PSW's return to work.

In addition, the licensee has failed to ensure:
1- That the policy to promote zero tolerance of abuse and neglect is compliant with s. 20(2) of the LTCHA, 2007, specifically related to neglect (see WN #3);
2- That all staff were provided with training on the required contents of the policy

to promote zero tolerance of abuse and neglect of residents (see WN #2 and CO #002);
3- That the licensee immediately investigated and took appropriate action in response to an incident of alleged neglect (see WN #4); and
4- That the Director was notified immediately of reasonable grounds to suspect neglect of a resident by the staff member (see WN #5).

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it was identified as an isolated incident affecting one resident. The compliance history is a level 3 with previous related non-compliance in the last 36 months, including:
- Inspection #2017_665551_0011, Voluntary Plan of Correction for s. 20(1)
- Inspection #2017_665551_0011, Written Notification for s. 23(2)
- Inspection #2017_665551_0011, Written Notification for s. 24(1)
(148)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 02, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Order / Ordre :

The licensee must be compliant with LTCHA, 2007, s.76 (4)

Specifically the licensee shall:
1- Review and revise the long-term care home's policy to promote zero tolerance of abuse and neglect of residents. The revision will ensure the inclusion of neglect as necessary;
2- Provide training to all staff members on the home's revised policy to promote zero tolerance of abuse and neglect of residents. The training will include, at minimum, all required content of the policy as described by s. 20(2) of the LTCHA, 2007 and s.96 of O. Regulation 79/10;
3- Ensure that staff understand and demonstrate knowledge of the home's policy to promote zero tolerance of abuse and neglect of residents; and
4- Maintain a documented record of the training provided.

Grounds / Motifs :

1. The licensee failed to ensure that that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

In accordance with section 76 (1) and (2) of the LTCHA, 2007 and section 219 (1) of O. Regulation 79/10, all staff are to receive training in the long-term care home's policy to promote zero tolerance of abuse and neglect of residents and that staff will be provided such training at annual intervals. The required contents of the home's policy to promote zero tolerance of abuse and neglect of residents is described in section 20 (2) of the LTCHA, 2007 and section s.96 of O. Regulation 79/10.

As described by WN #1, related to section 19 of the LTCHA, 2007, a critical incident report was submitted to the Director describing the alleged neglect of resident #003. It was demonstrated that several staff had information that would have been reasonable grounds to suspect neglect, however, action to protect the resident was delayed.

The lead for education in the home, was identified as the ADOC, who reported that all staff in the home are required to compete annual mandatory training on the policy to promote zero tolerance of abuse and neglect of residents. The ADOC identified six online courses that are to be completed by all staff as the training on the policy to promote zero tolerance of abuse and neglect of residents.
The following were the online courses identified:
1- Abuse Prevention One is One too Many Part 2
2- Abuse Prevention One is One too Many Part 5
3- Critical Incidents Part 1: Categories and Timelines for Reporting
4- Critical Incidents Part 2: Mandatory Reporting Responsibilities and Procedures
5- Critical Incidents Part 3: Whistle Blowing Protection
6- Legislated Required Programs

The Inspector reviewed the training record of RN #109, RPN#113, RN #115 and PSW #103 who had completed the six required courses within the 2018 calendar year. In review of the training record for RN #108 and PSW #107, four to five courses had not been completed including the three courses titled Critical Incidents, to which mandatory reporting was discussed.

The Inspector reviewed the above six identified courses and found that the training lacks in the following required areas:
- provide that abuse and neglect are not to be tolerated;
- clearly set out what constitutes abuse and neglect;
- contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
- shall set out the consequences for those who abuse or neglect residents;
- procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

- procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
- measures and strategies to prevent abuse and neglect;
- the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation;
- the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care; and
- situations that may lead to abuse and neglect and how to avoid such situations.

Additional non-compliance was identified related to s. 20 of the LTCHA, 2007 (see WN #3). As indicated, the licensee's policy to promote zero tolerance of abuse and neglect of residents was lacking in content related specifically to neglect.

(Log 001213-19)
(148)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 02, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 2nd day of May, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : AMANDA NIXON

Service Area Office /
Bureau régional de services : Ottawa Service Area Office