Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jul 23, 2020	2020_781729_0011	003904-20	Critical Incident System

Licensee/Titulaire de permis

Eden House Care Facility Inc.
c/o 2663649 Ontario Inc. 295 Adelaide Street West, Suite 4007 TORONTO ON M5V 0L4

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

Eden House Nursing Home
5016 Wellington County Road 29, R.R. #2 GUELPH ON N1H 6H8

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

KIM BYBERG (729)

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): July 20 - 22, 2020.

The following intakes were completed within the Critical Incident inspection:

Log #003904-20, related to an allegation of resident abuse.

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

During this inspection, inspector toured and observed resident care areas; and common areas, observed residents and the care provided to them, reviewed relevant clinical records, relevant policies and procedures, schedules, education records, home's investigation notes; and observed the general maintenance, cleanliness, safety and condition of the home.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Dignity, Choice and Privacy
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the rights of resident #001 were full respected and promoted and that when they refused consent to treatment, that their right was respected.

On a specified date and time, PSW #108 was attempting to provide care to resident #001. The resident displayed actions that would indicate refusal of care being offered. PSW #108 said that they re-approached resident #001 who continued to refuse the care. PSW #108 witnessed PSW #110 complete an action to resident #001 that forced them to accept the care.

PSW #108, #103 and #107 all shared that resident #001 often refused the specified care, and when that happened they would not provide the care.

PSW #107 and #108 said that when any resident does not want care or treatment to be performed, they re-approach, or ask another staff member for assistance. They shared that the care provided to resident #001 by PSW #110 was considered a refusal of care and unacceptable.

DOC #101 stated that resident #001's response to the care provided was considered a refusal of care.

The licensee failed to ensure that the rights of resident #001 were fully respected and promoted and that when they refused consent to treatment, that their right was respected. [s. 3. (1) 11. ii.]

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 every resident has the right to give or refuse consent of any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent, 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 has failed to ensure that RN #109 complied with the home's policy that promoted zero tolerance of abuse and neglect of residents.

On a specified date, PSW #108 and #111 witnessed PSW #110 provide specified care to resident #001 after they had refused the care.

PSW #108 said they reported the incident to RN #109 after it occurred.

Review of resident #001's progress notes, and clinical record did not include the allegation, an assessment of the resident or the care and treatment of resident #001 provided as a result of the allegation. A risk management report was not completed as a result of the alleged abuse.

A review of point of care documentation and the staff schedules showed that PSW #110 continued to work in the home providing care to residents for two days after the allegation was reported to RN #109.

The home's policy titled "Abuse and Neglect Prevention" subsection 3.2 last revised March 2018, stated that the DOC and registered staff shall ensure that the immediate needs of the resident are attended to, and included ensuring the residents safety immediately and on an ongoing basis, medical assistance, assistance of personal care, emotional support and arrangements of ongoing emotional and physical support and care. The policy stated that registered nursing staff/director of care shall document a detailed description of the incident in the resident's record. The documentation is to outline a description of the incident and physical findings and the care and treatment provided.

RN #109 said that they did assess resident #001 and could not remember if they completed any documentation in the resident chart or risk management report. RN #109

shared that when an incident of alleged abuse occurs that they are to assess the resident, document in the home's risk management report and call the DOC.

DOC #101 said they expected that a head to toe assessment of the resident would have been completed and documentation in the risk management report would have been done. DOC #101 acknowledged that the home's policy for abuse and neglect prevention was not followed.

The licensee has failed to ensure that RN #109 complied with the home's policy that promoted zero tolerance of abuse and neglect of residents. [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 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, 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 report an incident immediately to the Director when a person had reasonable grounds to suspect that staff to resident alleged abuse towards resident #001 occurred or may have occurred.

The home submitted a critical incident (CI) report to the Ministry of Long-Term Care (MLTC) on a specified date, stating that an incident of alleged abuse towards resident #001 two days earlier.

On a specified date and time, PSW #108 and #111 witnessed PSW #110 provide specified care in a forced manor to resident #001 after they had already refused care.

Written statements from PSW #108, #110, and #111 were obtained by the home on two days after the allegation occurred.

PSW #108 shared that they reported the incident to RN #109, after the incident occurred on a specified date. PSW #108 said they were aware of the mandatory reporting legislation and should have reported to DOC #101 directly.

RN #109 shared that they informed DOC #101 in a specified manner the day it occurred, and stated that PSW #111 who also witnessed the incident, told RN #109 that they would report the incident to the DOC. RN #109 acknowledged that the way they reported to DOC #101 may not have been clear, that they were aware of the mandatory reporting legislation, and stated that the home wanted the reports to go to the DOC first.

DOC #101 shared that the information they received from RN #109 was not clear, and when PSW #111 met with DOC #101 two days later, to report the allegations, DOC #101 then reported the allegation to the Director.

The licensee failed to report an incident immediately to the Director when a person had reasonable grounds to suspect that staff to resident alleged abuse towards resident #001 occurred or may have occurred. [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 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:

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, to be implemented voluntarily.

Issued on this 27th day of July, 2020

[redacted]

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

Original report signed by the inspector.