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
Feb 25, 2019	2019_514566_0003	019764-17, 019766-17, 019954-17, 024439-17, 027135-17, 027204-17, 002747-18, 027479-18, 029558-18, 002436-19	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
55 John Street Metro Hall, 11th Floor TORONTO ON M5V 3C6

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

Fudger House
439 Sherbourne Street TORONTO ON M4X 1K6

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

ARIEL JONES (566), JULIEANN HING (649)

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): January 28, 29, 30, 31, February 1, 5, 6, 7, 8, 11, 12, 13, 14, 15, 19, and 20 (off-site), 2019.

The following critical incident system (CIS) inspections were conducted during this inspection:
- log #019954-17 / CIS #M524-000024-17, log #019764-17 / CIS #M524-000022-17, log #027204-17 / CIS #M524-000040-17, and log #019766-17 / CIS #M524-000023-17 related to abuse;
- log #027479-18 / CIS #M524-000028-18 related to abuse and responsive behaviours;
- log #024439-17 / CIS #M524-000032-17 related to falls prevention and management;
- log #027135-17 / CIS #M524-000038-17 related to an injury of unknown cause; and
- log #002436-19 / CIS #M524-000004-19 related to transfers.

The following follow up inspections were conducted during this inspection:
- log #002747-18 related to air temperatures from report #2018_493652_0001; and
- log #029558-18 related to admission agreements from report #2018_324535_0009.

Complaint inspection report number #2019_641665_0003 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, assistant Administrator, acting Director of Nursing (A-DON), acting building services manager, acting senior security coordinator, nurse managers (NM), registered nursing staff (RN/RPN), personal support workers (PSW), custodian, handyman, residents and former residents.

During the course of the inspection, the inspectors observed staff to resident interactions, visitor to resident interactions, provision of resident care, air temperatures in identified home areas, reviewed residents' health care records, investigation notes, relevant policies and procedures, air temperature logs, and the home's resident admission agreement.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

4 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
O.Reg 79/10 s. 21.	CO #001	2018_493652_0001	566
O.Reg 79/10 s. 227. (3)	CO #001	2018_324535_0009	649

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 has failed to ensure that residents were protected from abuse by anyone.

Under O. Reg. 79/10, subject to subsection s. 2(1) of the Act, "physical abuse" means (c) the use of physical force by a resident that causes physical injury to another resident; (“mauvais traitement d’ordre physique”).

A Critical Incident Report (CIR) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date in October 2018, related to an allegation of physical abuse between residents #007 and #008. According to the CIR, a PSW observed resident #008 being held in an aggressive manner by resident #007. Resident #008 sustained an identified injury during this incident.

A review of resident #008's progress notes, indicated that on an identified date and time a PSW had observed resident #007 holding onto resident #008 in a specific manner. The residents were immediately separated.

Residents #007 and #008 were not interviewable.

During interviews with PSW #109 and RPN #110, they both confirmed the above incident between residents #007 and #008. According to RPN #110 neither resident was able to say what had happened, and a specific level of monitoring was started for resident #007 for an identified time period. RPN #110 further explained that resident #007 had an identified responsive behaviour and an identified communication barrier.

During interviews with NM #118, A-DON, and the Administrator, they confirmed that physical abuse had occurred since resident #008 had sustained an injury during their interaction with resident #007. [s. 19. (1)]

2. Under O. Reg. 79/10, subject to subsection s. 2(1) of the Act, "sexual abuse" means 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) On an identified date in August 2017, a CIR was submitted to the MOHLTC related to an allegation of sexual abuse made by resident #003 against visitor #103. According to the CIR, resident #003 reported that visitor #103 touched them inappropriately. At the time of the report, resident #003 stated that the incident had occurred approximately two months prior and they had not reported it earlier because they did not think that anything would be done.

A review of the home's investigation notes indicated during the interview with visitor #103 they admitted to touching resident #003 as part of a conversation.

In an interview with resident #003, they described to the inspector how visitor #103 had touched them on an identified body part and how they responded by telling visitor #103 to knock it off. When asked by the inspector how this made them feel, the resident replied that they felt unsafe, annoyed and angry.

A review of the amended CIR indicated that visitor #103 was cautioned by the police not to get close to the complainant and to follow the restrictions established by the home.

B) Further review indicated there were other CIRs submitted to the MOHLTC involving visitor #103 related to allegations of sexual abuse.

On the same date in August 2017, another CIR was reported to the MOHLTC related to an allegation of sexual abuse made by resident #006 against visitor #103. According to the CIR, resident #006 reported that visitor #103 approached them and touched a specific body part. Resident #006 told the visitor off right away and said a loud "no".

A review of the home's investigation notes indicated that during the interview with visitor #103 they admitted to an identified contact with resident #006 and denied any further contact.

In an interview with resident #006, they recalled the incident that took place with visitor #103. According to the resident, visitor #103 had taken their hand and given a specific sign. The resident indicated that this incident made them feel awful.

A review of the amended CIR indicated that visitor #103 was cautioned by the police not to get close to the complainant and to follow the restrictions established by the home.

A letter written by the home from an identified date was sent to visitor #103 outlining specific restrictions that were effective as of a second identified date, 11 days after the submission of the incident report.

C) A third CIR was submitted to the MOHLTC on an identified date in November 2017, related to an allegation of sexual abuse. According to the CIR, resident #004 was touched by visitor #103 on an identified body part, and they felt assaulted from being

touched by this person. Further review of the CIR indicated that the incident occurred in an identified public home area and there were two other residents present at the time of the alleged incident.

In an interview with resident #004 who no longer resides in the home, they recalled the incident where visitor #103 touched them on an identified body part in a public area. They responded by telling visitor #103 to stop, and the visitor had responded by saying that nobody would know. Resident #004 confirmed that visitor #103's touch was deliberate, and that visitor #103 had not asked their permission to touch them and this incident made them feel dirty.

According to the home’s investigation, resident #005 was present when the incident occurred between resident #004 and visitor #103. According to the home’s interview with resident #005 they did not see visitor #103 touching resident #004 but heard resident #004 saying, “don’t touch me”.

A review of the home’s investigation notes indicated that during an interview with visitor #103 they admitted to touching resident #004 on the identified body part. The CIR was amended eight days later to reflect visitor #103's admission.

In an interview with NM #100, they explained that after the first two identified incidents involving visitor #103 the home took steps to reduce the amount of time the visitor was spending in the home. According to NM #100, a staff member was expected to escort visitor #103 within the building.

According to the home’s investigation notes, and resident and staff interviews, it was confirmed that there were no staff members escorting visitor #103 in the identified home area when the incident occurred between resident #004 and visitor #103.

In an interview with NM #102, when asked if sexual abuse occurred between resident #004 and visitor #103, they replied that it was non-consensual and the resident felt that their rights were violated and had not provided consent to being touched.

In an interview with the Administrator, they stated that visitor #103 had touched resident #004 without their permission and that there was non-consensual touching.

The incidents between residents #003, #004, and #006, and visitor #103 demonstrated, based on the above definition, that sexual abuse had occurred.

The severity of this finding was actual harm. The scope was pattern. A review of the home's compliance history indicated a history of non-compliance related to s. 19(1); a VPC was issued under s. 19(1) during RQI inspection #2017_484646_0010 dated July 26, 2017. According to the judgement matrix, a compliance order (CO) is warranted; however, it has been confirmed through the inspection and the home's compliance history since the time of these incidents, that non-compliance related to visitor to resident sexual abuse has been addressed and rectified by the home. A written notification (WN) is being issued. [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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A CIR was submitted to the MOHLTC on an identified date in August 2017, related to an incident that occurred between residents #001 and #002 the day before. According to the CIR resident #002 was hit on an identified body part by resident #001, no injuries were noted upon assessment.

Residents #001 and #002 were not in the home during this inspection.

Further review of the CIRs submitted and amended by the home, indicated that resident #001 required a specific level of monitoring to ensure the safety of other residents. According to the CIR, resident #001 denied hitting resident #002.

A review of resident #001's care plan, updated on the same date the CIR was submitted, indicated a specific level of monitoring.

A review of resident #001's progress notes and staff supplement summary provided by the home for an identified four day period following the incident indicated the specific level of monitoring had not been provided to resident #001 on four identified shifts.

In an interview with NM #102, they acknowledged that the specific level of monitoring for resident #001 was updated in their care plan on an identified date, and confirmed that the specific level of monitoring was not provided to resident #001 on the identified shifts.

In an interview with the A-DON, they confirmed that the specific level of monitoring was not provided for resident #001 on the identified shifts and stated that care was not provided as per the plan of care. [s. 6. (7)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

On an identified date in November 2017, a CIR was submitted to the MOHLTC related to an injury of unknown cause sustained by resident #017. The report detailed that while PSW #121 was providing care to the resident two days earlier, they noted an injury to an identified body part and that the resident was in pain. The resident was transferred to hospital and received a specific diagnosis related to the injury.

A review of the home's investigation notes into the incident indicated that on identified date and shift in November, three days prior to submission of the CIR, resident #017 was lowered to the floor by PSW #109 during provision of care. RPN #120 responded, and the two staff then transferred resident #017 from the floor to their bed using a mechanical lift. The incident was not reported on the 24 hour shift report. The home's investigation notes indicated further that on an identified date ten days after the incident, RPN #120 was instructed to complete a late entry progress note and a resident incident report.

A review of resident #017's progress notes, indicated that there was an entry made by RPN #120 on the identified date and shift that the incident occurred, but that it did not reference the incident by which the resident was lowered to the floor during care or the intervention whereby the resident was transferred from the floor to their bed using a mechanical lift. There were also no related written assessments or incident reports noted in the resident's paper chart for this time period. A late entry progress note authored by RPN #120 ten days later included the RPN's account of the incident.

During an interview, RPN #120 indicated that they did not document the interventions or complete any written assessments due to the PWS's report that the resident did not fall but was lowered to the ground. They did not consider it to be an incident at the time.

RPN #120 indicated further that they asked the resident if they were in pain and conducted an abridged assessment once the resident was in bed. RPN #120 indicated that, in retrospect, the incident should have been documented and communicated to the next shift.

During an interview, RN #122 who worked the following day confirmed there was no documentation or communication from previous shifts regarding any falls or bruising which could have explained the injury to resident #017 that was discovered on their shift.

During an interview, NM #100 confirmed that following this incident, the nurse did not conduct a proper assessment, document the incident in the progress notes, or endorse the incident to the next shift for follow-up, and that following the home's investigation, the staff member received an expectation letter outlining their duties around reporting and documentation. [s. 30. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

On an identified date in November 2017, a CIR was submitted to the MOHLTC related to an injury of unknown cause sustained by resident #017.

A review of resident #017's progress notes indicated that while PSW #121 was providing care to the resident two days earlier, they noted an injury to an identified body part and that the resident was in pain. The physician assessed and recommended the resident be sent to hospital. There was a late entry progress note made by RPN #120 one week after submission of the CIR which indicated that PSW #109 claimed that they lowered resident #017 to the floor due to the resident's identified behaviour during care.

A review of resident #017's care plan updated on a specific date in July 2017, and RAI-

MDS assessment from a specific date in October 2017, indicated the resident required a specific level of assistance for personal hygiene, bed mobility and transfers, and that they were at high risk for falls.

During an interview, PSW #109 indicated they were the regular caregiver for resident #017. At the time of the incident they were transferring resident #017 on their own when the resident began sliding downward, so they helped lower the resident to the floor in order to avoid a fall. They indicated further that they would regularly transfer the resident on their own.

During an interview, RPN #120 indicated that from what they could recall, at the time of the incident resident #017 required assistance of an identified number of staff for personal care, transferred in a specific way, and was unable to follow directions. RPN #120 confirmed that they responded to a noise coming from resident #017's room on the identified shift and when they entered the room, resident #017 was observed on the floor with PSW #109 present. RPN #120 indicated they could not remember what type of care PSW #109 was providing at the time, but indicated there were no other staff present. RPN #120 confirmed that resident #017's care plan was not being followed at the time of the incident.

A review of the home's investigation notes and interview with NM #100 confirmed that PSW #109 failed to follow resident #017's care plan, that PSW 109's transfer of resident #017 was unsafe, and that the resident sustained an injury as a result of the incident. NM #100 indicated further that PSW #109 received disciplinary action for their involvement in this incident.

The severity of this finding was actual harm. The scope was isolated. A review of the home's compliance history indicated the home did not have a history of non-compliance related to r. 36 over the past three years. According to the judgement matrix, a CO is warranted; however a WN has been issued. It has been confirmed through the inspection that the non-compliance has been addressed and rectified by the home since the time of its occurrence. [s. 36.]

Issued on this 28th day of February, 2019

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

Original report signed by the inspector.