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 le Loi de 2007 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
Nov 09, 2017;	2017_610633_0015 (A1) (Appeal\Dir#: DR#074)	013758-17	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF BRUCE
41 McGivern Street P.O. Box 1600 WALKERTON ON N0G 2V0

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

GATEWAY HAVEN LONG TERM CARE HOME
671 FRANK STREET P.O. BOX 10 WIARTON ON N0H 2T0

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

Ontario

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Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

SHERRI COOK (633) - (A1)(Appeal\Dir#: DR#074)

Amended Inspection Summary/Résumé de l'inspection modifié

NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector's order. The Director's review was completed on 09/11/2017. The order was altered to reflect the Director's review.

Issued on this 9 day of November 2017 (A1)(Appeal\Dir#: DR#074)

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

Original report signed by the inspector.

Ontario

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

SHERRI COOK (633) - (A1)(Appeal/Dir# DR#074)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): July 17-21, 24-27, 2017.

The following inspections were conducted concurrently during this inspection:

Log #028463-16 / M526-000012-16- Critical Incident related to responsive behaviours.

Log #026744-16 / M526-000011-16- Critical Incident related to a resident fall.

Log #030773-16 / M526-000016-16- Critical Incident related to a resident fall.

Log #019064-16 / M526-000016-16- Critical Incident related to a resident fall.

Log #016567-16 / M526-000005-16- Critical Incident related to alleged abuse.

Log #007874-17 / M526-000010-17- Critical Incident related to alleged abuse.

Log #005340-17 / M526-000007-17- Critical Incident related to alleged abuse.

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Recreation and Leisure Manager, a Clinical Care Coordinator, a Behavioural Support Ontario Registered Nurse, Registered Nurses, a Resident Assessment Instrument Coordinator, Registered Practical Nurses, Personal Support Workers, a Housekeeper, a Residents' Council member, a Family Council member, family members and residents.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Additionally, the inspector(s) observed medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Falls Prevention

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Skin and Wound Care

Sufficient Staffing

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

- **8 WN(s)**
- **6 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	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 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 has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur immediately reported the suspicion and the information upon which it was 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 a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident.

A Critical Incident System (CIS) Report related to the alleged abuse a resident by a staff member was submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the Director of Care (DOC), thirteen days after the alleged incident occured.

In interviews with the identified staff member, the resident's family member and the Administrator, they stated that the concern regarding alleged abuse was expressed by the identified resident at a family conference. The progress note in PointClickCare (PCC) for the resident stated that the family was happy with the care and a few concerns were brought forward and were addressed. In an interview with the resident they were unable to recall the incident and stated that the staff had been good.

In an interview with a staff member regarding alleged abuse, they said that they were present at the family conference and believed at the time that it was possible that abuse had occurred. This staff member also said that they would have reported to the DOC immediately or the next time that they saw them.

In interviews with the Administrator they stated that the DOC became aware of the incident after the family conference and agreed that there was a gap in reporting to the Director. The Administrator explained that the resident's family member and their Power Of Attorney (POA) went away and the DOC was unable to reach them for some time.

Record review of the policy titled Prevention of Abuse and Neglect last reviewed November 2012, stated that each employee must immediately report suspicions of abuse to their Supervisor, Charge Nurse, DOC or Administrator and Appendix A: Table 1 titled LTCHA Section 24(1) - Reporting Certain Matters to the Director stated that "all alleged abuse by anyone was to be reported the MOHLTC immediately within business hours".

In further interviews with the Administrator they stated that the Prevention of Abuse and Neglect policy last reviewed November 2012, the MOHLTC decision trees and Appendix A were used and followed in the home related to reporting abuse and the Administrator agreed that the incident of alleged abuse expressed by the resident at the annual family conference was not reported to the MOHLTC immediately.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that the alleged abuse of a resident by a staff member had occurred or may have occurred and the suspicion and the information upon which it was based upon was immediately reported to the Director. [s. 24. (1)]

2. A Critical Incident System (CIS) Report related to the alleged abuse of a resident by another resident was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date and time, by the Director of Care (DOC). The CIS stated that this incident occurred on a statutory holiday and the MOHLTC after hours pager was not contacted.

The incident note in PointClickCare (PCC) for the resident, and the home's investigation records documented that a staff member had called the DOC at their home at a specific date and time, to report that a resident had been physically

aggressive towards another resident. This resident was totally dependent on staff for all care and mobility.

In interviews with registered staff members they stated that their role was to report any alleged abuse to the DOC immediately and they did not complete any mandatory reporting to the MOHLTC either by initiating a CIS report or by calling the after hours pager. They stated that this was the role of the DOC.

In further interviews with the Administrator they stated that they and the DOC did not have computer access to the MOHLTC mandatory reporting system from home and that unless an incident, that may include alleged abuse, was considered "major" they would not come in to the home to complete the CIS report and would wait until the next business day. The Administrator agreed that the registered staff did not submit CIS reports to the MOHLTC and further explained that the DOC would complete the report to the MOHLTC, or the Administrator in their absence, on the next business day if the incident occurred after hours or on a weekend.

Record review of the policy titled Prevention of Abuse and Neglect last reviewed November 2012, stated that each employee must immediately report suspicions of abuse to their Supervisor, Charge Nurse, DOC or Administrator and that the MOHLTC decision trees were to be used as a guide related to the time frames to report alleged abuse which included "via the after hours contact number" and/or the Critical Incident System (CIS) during business hours. Appendix A: Table 1 titled LTCHA Section 24(1) - Reporting Certain Matters to the Director stated that "all alleged abuse by anyone was to be reported the MOHLTC immediately" within business hours and "by the after hours pager at all other times including statutory holidays".

The Administrator stated that the behaviour of the identified resident was "scary". The Administrator also said that they were aware of the after hours pager and thought that the DOC may have called in the past. The Administrator agreed that the after hours pager was not called and the incident was not immediately submitted to the Director.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by another resident had occurred or may have occurred was immediately reported to the Director. [s. 24. (1)]

3. A Critical Incident System (CIS) Report related to the alleged abuse of two

residents by a staff member was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date and time, by the Director of Care (DOC). The critical incident was documented as occurring on a specific date and time.

In an interview with the identified staff member, they stated that they were working the night shift, when they were told by the registered staff who was in charge to leave the floor and go home. The home’s investigation notes showed that the registered staff member in charge sent an email to the Director of Care (DOC) on a specific date and time. In an interview with Registered Nurse (RN), who was on-call on at the time, they stated that they had directed the registered staff member to immediately contact the DOC as they did not have the DOC's home number at home.

Record review of the policy titled Prevention of Abuse and Neglect last reviewed November 2012, stated that each employee must immediately report suspicions of abuse to their Supervisor, Charge Nurse, DOC or Administrator and that the MOHLTC decision trees were to be used as a guide related to the time frames to report alleged abuse which included "via the after hours contact number and/or the Critical Incident System (CIS) during business hours". Appendix A: Table 1 titled LTCHA Section 24(1) - Reporting Certain Matters to the Director stated that "all alleged abuse by anyone was to be reported the MOHLTC immediately by initiating the CIS within business hours Monday – Friday 8am-5pm".

In further interviews with the Administrator they stated that the expectation was that all allegations of abuse be reported to the MOHLTC immediately and agreed that the alleged incident of abuse was not reported to the MOHLTC on time.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that the alleged abuse of two residents by a staff member was immediately reported to the Director.

The severity of the issue was minimal harm, the scope of the issue was widespread and the home had a history of multiple unrelated non-compliance. [s. 24. (1)]

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. 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 without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that the written policy to promote zero tolerance of abuse policy is complied with.

Record review of the policy titled Prevention of Abuse and Neglect, last reviewed November 2012, stated that:

-Abuse of a resident was defined as "any action against a resident, that the person knew or ought to have known would cause, or reasonably be expected to cause, harm to the resident's safety or well-being".
-"The charge Registered Nurse (RN) would follow the Investigations of Allegations of Abuse policy to determine if there were reasonable grounds to suspect that the abuse had occurred and they would also initiate the initial investigation upon receiving a report of an allegation of abuse".
-"All staff interviewed were to write and sign statements" and these "shall be retained on file".
-"The supervisor to whom the abuse was reported to should prepare a written incident report that contained who was involved, written signed statements from all witnesses, what was observed, when the incident happened, any related events leading up to the incident and the status which included the impact of the abuse,

assessment for injury and any treatments required, follow-up assessments" and "future prevention was to be included by documenting their opinion of ways the event could have been prevented".
-"Each employee that suspected abuse of a resident must immediately report the suspicions to their supervisor and the applicable reporting of abuse decision trees from the MOHLTC would be used to determine the reporting criteria and time frames".
-It was the "responsibility of management to ensure that a thorough investigation was completed and acted on in accordance with the Investigation of Allegation of Abuse policy".
- Appendix A: Table 1 titled LTCHA Section 24(1) - Reporting Certain Matters to the Director stated that "all alleged abuse by anyone was to be reported the MOHLTC immediately by any person who was aware of an incident of abuse" and they were to also "initiate the CIS within business hours or by phoning the after hours pager at all other times and statutory holidays".
-"The abuse policy would be reviewed with all employees and volunteers annually".

-"An analysis of every incident would be completed and included in the annual evaluation of the Prevention of Abuse and Neglect program at least once in every calendar year to determine the effectiveness of the policy".

Three Critical Incident System (CIS) Reports related to the alleged abuse of residents were not submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the Director of Care (DOC) immediately and the MOHLTC after hours pager was not called when appropriate.

Record review of the the home’s investigation records that were provided by the Administrator did not include the initial investigations and written documentation that was to be completed by the registered staff in charge at the time of the incident as stated in the Prevention of Abuse and Neglect policy last reviewed November 2012.

In interviews with staff members they said that they were to report alleged abuse to their supervisor and that the DOC would complete the mandatory reporting to the MOHLTC. An RN said that if the incident occurred on a weekend or after hours then they would be considered the supervisor in the building and only if they thought the incident was abuse would they notify the DOC or Administrator and this depended upon who was on call that weekend. They also said that the expectation was that abuse was reported right away to registered staff and the registered staff

would take the statements right away as people don't remember. The RN further stated that they may ask the staff to write it down and if they felt that abuse has occurred and explained that their role was to document the incident and the DOC and Administrator were responsible to complete the investigation. They also further stated that they would send an email to the Administrator and DOC as their documentation of the incident and they would not complete any reporting related to abuse to the Ministry as the DOC and/or the on call manager was responsible for this as well. Another RN said that they did not complete abuse investigations or paper work other than possibly risk management and agreed that they do not complete the mandatory CIS reports to the MOHLTC as this was the role of the DOC.

In an interview with the Administrator they said that they and the DOC were the lead for the Prevention of Abuse and Neglect policy review and they stated that they did not have an Abuse program. The Administrator was unable to provide the "Investigation of Allegation of Abuse Policy" stated in the Prevention of Abuse and Neglect policy, lasted reviewed November 2012 as the process for alleged abuse investigations that was to be followed by the charge RN. The Administrator said that the home does not use this and explained that the registered staff would usually just send an email or call them at home, if the incident occurred after hours. The Administrator also said that the DOC completed the mandatory CIS reports to the MOHLTC, or the Administrator in their absence or when on-call, as the registered staff were not trained. In further interviews, the Administrator explained that they did not have computer access to the mandatory reporting system from their home and stated that unless the situation was a case of severe abuse they would not come in to the home as this could wait until Monday. When asked if there was a situation of alleged verbal abuse the Administrator stated that this too would be addressed by the DOC on the next business day if the incident occurred after hours.

When the Administrator was asked for the written evaluation of effectiveness of the Prevention of Abuse and Neglect policy and documentation of the changes made to this policy, the Administrator was unable to provide a written evaluation and agreed that the policy had not been evaluated since 2012.

Record review of the staff education materials related to Prevention of Abuse and Neglect for 2016 with the Administrator, they said that the Abuse policy was not included in the 2016 educational booklet that was reviewed by staff at the annual in-service training.

In a telephone interview with the Administrator they said that that the staff education for 2016 did not include reviewing the Prevention of Abuse and Neglect policy as they thought that the College of Nurse of Ontario (CNO) abuse modules provided to staff online were sufficient.

The licensee has failed to ensure that without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that the written policy to promote zero tolerance of abuse was complied with.

The severity of the issue was minimal harm/risk or potential for actual harm/risk, the scope of the issue was widespread and the home had a history of multiple unrelated non-compliance. [s. 20. (1)]

Additional Required Actions:

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

(A1)(Appeal/Dir# DR#074)
The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following right of a resident was fully respected and promoted: 1. Every resident had the right to be treated with courtesy and respect and in a way that fully recognized the resident’s individuality and respected the resident’s dignity.

During an interview in Stage 1 of the Resident Quality Inspection (RQI) with a resident, they shared that during a meal on a specific date, they had activated their call bell for assistance with specific care. The resident shared that when no one came they went back to the dining room to ask staff if they could help. The resident said that staff advised them that they could not leave the dining room while feeding residents and that they would have to wait. The resident also said that there were three Personal Support Workers (PSW's) and a Nurse in the dining room at that time, but they could not recall their names. The resident stated that they returned to their room to wait and staff did not come to their room for approximately 30 minutes. The resident further stated that by the time staff arrived to assist they had an accident. The resident also said that they required assistance with most of their care and it was very upsetting when staff acted as though it was nothing to have to wait.

Review of the resident's clinical record identified specific diagnoses and suggested that the resident did not have a cognitive impairment. The plan of care also stated that the resident was to receive this specific care at their request and they required extensive assistance of two staff members for this care.

During an interview with PSW's they stated that they were both working a short shift on this date where the resident resided. The staff were asked what the process was when a resident activated their call bell during a meal. The staff said that it depended on who the resident was that activated their bell and stated that if it was a resident where they were concerned for their safety they would respond immediately and if it was a resident that rang their bell frequently and they knew the resident was likely alright, they may not respond to the bell at the time. The staff also said they had been told by management that it was their priority to feed residents in the dining room and that the identified resident would have to wait for this specific care. The staff could not recall if this resident had rang their bell during a meal on this specific day, and stated that the reason for not remembering was that it happened so often.

In interviews with the the Administrator and the Director of Care they stated that staff were instructed to respond to all call bells and if they were in the middle of feeding a resident then one of the other staff or the registered staff could respond to the call bell. They stated that they would have never have advised a staff member to not to respond to a call bell. The Administrator and the Director of Care said that in the situation that involved the identified resident the staff should have, at a minimum, gone to see what the resident needed and if the need was urgent then the staff should request a second staff to come and assist. They also said that if there was no one available in the dining room the staff could always call a staff member from another area or the registered staff could help. The Director of Care acknowledged that staff had not provided care for the identified resident as per their plan of care related to this specific care, which identified that staff were to respond at the resident's request.

The licensee of a long-term care home has failed to ensure that an identified resident was treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

The severity of the issue was minimal harm/risk or potential for actual harm/risk, the scope of the issue was isolated and the home had a history of non-compliance in a similar area. [s. 3. (1) 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 every resident is treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

During observations on specific dates, a resident was observed seated in their device with a specific intervention.

The resident's plan of care was reviewed and there was no documentation related to the device and there was no assessment related to the use of the device and this specific intervention.

A staff member stated that the resident often would request this intervention for comfort and at these times the staff would initiate this specific intervention for the resident. The staff also said that while the resident was up they would repositioned them every couple of hours. When asked if there was specific direction related to this intervention, the staff said they were not aware of any.

During an interview with another staff member, they said that registered staff should be made aware of residents that use this device and this should be documented in their plan of care and that parameters that surrounded the use of the device and interventions would also need to be documented. The staff acknowledged that the use of the device for the identified resident had not been included in their plan of care.

The licensee failed to ensure that there was a written plan of care for an identified resident that set out the planned care related to the use of their device and a specific intervention. [s. 6. (1)]

2. 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) Review of the Critical Incident System (CIS) stated that a resident was found on the floor on a specific date and time. The resident complained of pain in a specific body area and during assessment the resident exhibited grimacing with movement. The resident received medical treatment and interventions were put in place due to an injury.

Review of the identified resident's plan of care related to falls identified that the resident was a high risk for falls. Specific interventions were in place to mitigate the risk of falls at the time of the reported incident.

During an interview with the Director of Care (DOC), they stated that the resident was a high risk for falls and the home had put a number of interventions in place to mitigate the risk of falls. The DOC acknowledged that a specific intervention was in place at the time of the fall but staff had not done this.

The licensee has failed to ensure that the care set out in the plan of care specific to falls prevention was provided to a resident as specified in their plan of care.

B) A Critical Incident System (CIS) Report related to the alleged abuse of two residents by a staff member was submitted to the Ministry of Health and Long-Term Care (MOHLTC), on a specific date and time, by the DOC.

The home’s investigation records stated that this staff member was working independently with the resident on a specific date. The Minimum Data Set (MDS) and the care plan in PointClickCare (PCC) for the resident stated that the resident required total assistance for all care with two staff assistance.

In an email, a staff member stated that they had witnessed this staff member providing care to the identified resident alone.

In an interview with the identified staff member they stated that they were working this shift and they agreed that they had not checked the care plan for the resident

and had assisted the resident with care alone.

In an interview with the Administrator they agreed that the staff member was providing care to the resident alone and they should not have been.

The licensee has failed to ensure that the care set out in the plan of care related to staff assistance for care for a resident was provided to the resident as specified in their plan of care.

The severity of the issue was actual harm/risk, the scope of the issue was isolated and the home had a history of non-compliance in a similar area. [s. 6. (7)]

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 plan of care for each resident that sets out the planned care for the resident and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

In an interview with a Personal Support Worker (PSW), regarding a critical incident, they said that they were working the night shift and there was not a Registered Nurse (RN) working in the home. The PSW also said that this happened a lot.

In an interview with a RN they stated that they were on-call and not working in the home on this specific date and that there was not at least one RN working in the home at all times as they often ran short. In an interview with another RN, they agreed that RN's were on call and not present in the home and that an RN was not working in the home for all shifts. Both RN's said that this had been going on for a while.

In an interview with the Administrator they said that they had lost a full time RN in June, that a RN was not on call very often and RPN's were left in charge only in an emergency.

Record review of the staff schedules for a specific month documented seven shifts that an RN was not present and working in the home (thirteen per cent) .

Review of the registered staff schedule for a specific period documented the following:
a) There were three full time Registered Nurses (RN's) and one part time RN on the staff schedule.
b) There were two out of twenty-eight day shifts (seven per cent); eleven and a half out of twenty-eight evening shifts (forty-one per cent) and four out of twenty-eight (fourteen per cent) of night shifts where there was no RN on duty and present in the home.

Review of the registered staff schedule for another specific period documented the following:
a) There were three full time RN's, one part time RN and a full time RN that was in orientation on the schedule.
b) There were four out of nineteen day shifts (twenty-one per cent); four and a half out of nineteen evening shifts (twenty-three per cent); and one out of nineteen (five

per cent) night shifts where there was no RN on duty and present in the home.

During an interview with the Director of Care (DOC) they acknowledged that the home did not have a RN that was an employee of the licensee and a member of the regular nursing staff on duty and present in the home at all times.

The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

The severity of the issue was minimal harm/risk or potential for actual harm/risk, the scope of the issue was isolated and the home had a history of multiple unrelated non-compliance. [s. 8. (3)]

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 at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written staffing plan for the nursing and personal support services program.

During an interview with the Administrator they said that they discuss staffing concerns and issues daily at their morning meeting and they had conducted a staff survey to gather input regarding staffing issues and based on this survey they had made several changes during the past year. When asked if the home had a staffing plan for the nursing and personal support services program that included a back up plan in the event of an emergency as well as an annual evaluation of the staffing program, the Administrator said that they did not have a written staffing plan and had not completed an annual evaluation of the nursing and personal support services program.

The licensee has failed to ensure that there was a written staffing plan for the nursing and personal support services program. [s. 31. (2)]

2. The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

A resident said that since early summer they had not been getting a specific care. The resident also said that they preferred a specific care but when the home was short of staff they often missed this care. The resident shared that it was upsetting when they had to miss this care as this was something that they looked forward to. When asked if the resident had brought their concern forward to the home, the resident said that they had spoken with management who acknowledged that they had been short staffed and in these situations they were not able to provide all residents with their preferred care, a specific times per week.

Review of the resident's plan of care, specific to this care, identified that the resident had a preference related to this care. Point of Care (POC) documentation for a specific period identified that the resident had not received their preferred care a specific amount of times.

During an interview with another resident they said that they had a preference related to this specific care. When asked if the resident received their preferred care they said that sometimes it was missed or mixed up. The resident stated that the staff did their best to give everyone this care but sometimes they were given a a different care instead.

The POC documentation for a specific period stated that the resident had not received their preferred care and had missed this care on specific dates.

PSW's shared that they often work short on the day shift when most of this care was completed. They said that there were four full time PSW's normally scheduled and the other units just had three PSW's. The PSW's said that when they were short anywhere in the home they would pull the fourth shift which would leave them short. The staff all said that this happened more days than not, particularly on weekends and in the summer. When asked how this might impact resident care, the PSW's said that they would not be able to do all of the residents' care and stated that some residents either didn't get the care or they would give them different care instead. The PSW's recognized that this was not ideal but they had no choice and explained that because most of the residents required two staff for

transfers there was just not enough staff available. When asked if the care was made up the next day the staff said that it was not.

Review of the staffing schedules for a specific period identified that on 19 out of 49 day shifts they were short staffed and the PSW shortage varied from 0.5 of a full time equivalent (FTE) to 2.0 FTE.

During an interview with the Director of Care (DOC) and the Administrator they said that when they were short staffed on days and unable to fill the shift they would normally pull a PSW staff where they have four full time PSW staff scheduled. When asked how that would impact a specific resident home area, the DOC said that they would instruct staff to focus on resident care. The DOC and the Administrator said that in terms of this specific care, the staff may have to do a different care or miss it. When asked if this care would be rescheduled, the DOC said they were unsure if this occurred. The DOC and the Administrator acknowledged that when they were short staffed, residents may not get their preferred care a specific amount of times as scheduled.

The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' care needs.

The severity of the issue was minimal harm/risk or potential for actual harm/risk, the scope of the issue was isolated and the home had a history of multiple unrelated non-compliance. [s. 31. (3)]

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 staffing plan for the nursing and personal support services program and that the staffing plan provides for a staffing mix that is consistent with residents' assessed care and safety needs, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee of a long-term care home has failed to ensure,
(b) that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) was considered in the evaluation;
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation

and the date that the changes and improvements were implemented was promptly prepared. O. Reg. 79/10, s. 99.

Three Critical Incident System (CIS) Reports related to the alleged abuse of residents were not submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the Director of Care (DOC) immediately, the after hours pager was not called when appropriate and investigations were not completed by the registered staff when they were in charge.

The policy titled Prevention of Abuse and Neglect was last reviewed November 2012. Under Step 5: "Evaluation of Incidents" it stated that "Administration would analyze every incident of abuse or neglect" and the "results would be considered in the annual evaluation at least once in every calendar year".

The policy titled Annual Program Evaluations last reviewed June 10, 2014, stated that "each program would be evaluated annually according to the Annual Program Evaluation schedule and documented on the program evaluation template". Under the heading "Administrative Services" it was stated that "Prevention of Abuse and Neglect program" would be "evaluated by the members of the leadership team".

In an interview with the Administrator they said that they and the DOC were the lead for the Prevention of Abuse and Neglect policy review and they did not have an Abuse program. When asked for the written evaluation of effectiveness of the Prevention of Abuse and Neglect policy and documentation of any changes made to this policy, the Administrator was unable to provide a written evaluation and agreed that the policy had not been evaluated since 2012. [s. 99. (b)]

The licensee of a long-term care home has failed to ensure,
(b) that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements were required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) was considered in the evaluation;
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented was promptly prepared. O. Reg. 79/10, s. 99.

The severity of the issue was minimal harm/risk or potential for actual harm/risk, the scope of the issue was widespread and the home had a history of multiple unrelated non-compliance. [s. 31. (3)]

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 that ensures,
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

The licensee failed to ensure that the device for a resident was applied in accordance with the manufacturer's instructions.

On a specific date and time, a resident was observed with their device that was not applied appropriately.

During an interview with a Personal Support Worker (PSW) they were asked if the resident had their device properly applied. The PSW reviewed the application and stated that it was not applied correctly. The PSW tried to correctly apply the device and was unable to do so. The PSW stated that they would contact maintenance.

On another date and time the same resident was observed a second time with their device applied incorrectly.

The Manager of Recreation and Leisure told the inspector that they did not keep the manufacturer instructions as they were usually given to family. After the home contacted their equipment provider, they gave the inspector a copy of the instructions that stated how the device should fit.

During an interview with the RAI Coordinator they acknowledged that the identified resident's device was not applied correctly.

The licensee failed to ensure that the device for a resident was applied in accordance with the manufacturer's instructions.

The severity of the issue was minimal harm/risk or potential for actual harm/risk, the scope of the issue was isolated and the home had a history of related non-compliance in a similar area. [s. 110. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:

1. Staff apply the physical device in accordance with any manufacturer's instructions, to be implemented voluntarily.

Issued on this 9 day of November 2017 (A1)(Appeal/Dir# DR#074)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

London Service Area Office
130 Dufferin Avenue, 4th floor
LONDON, ON, N6A-5R2
Telephone: (519) 873-1200
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Bureau régional de services de London
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LONDON, ON, N6A-5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : SHERRI COOK (633) - (A1)(Appeal/Dir# DR#074)

Inspection No. / No de l'inspection : 2017_610633_0015 (A1)(Appeal/Dir# DR#074)

Appeal/Dir# / Appel/Dir#: DR#074 (A1)

Log No. / No de registre : 013758-17 (A1)(Appeal/Dir# DR#074)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Nov 09, 2017;(A1)(Appeal/Dir# DR#074)

Licensee / Titulaire de permis : CORPORATION OF THE COUNTY OF BRUCE
41 McGivern Street, P.O. Box 1600, WALKERTON, ON, N0G-2V0

LTC Home / Foyer de SLD : GATEWAY HAVEN LONG TERM CARE HOME
671 FRANK STREET, P.O. BOX 10, WIARTON, ON, N0H-2T0

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Heather Penny

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 CORPORATION OF THE COUNTY OF BRUCE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

The license shall ensure:

1. That a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident and 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 is immediately reported to the Director.

2. That all immediate mandatory reporting includes after business hours, on weekends and on statutory holidays.

3. That all staff receives training on mandatory reporting to the Director.

Grounds / Motifs :

1. The licensee has failed to ensure that a person who had reasonable grounds to

suspect that any of the following had occurred or may occur immediately reported the suspicion and the information upon which it was 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 a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident.

A Critical Incident System (CIS) Report related to the alleged abuse a resident by a staff member was submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the Director of Care (DOC), thirteen days after the alleged incident occured.

In interviews with the identified staff member, the resident's family member and the Administrator, they stated that the concern regarding alleged abuse was expressed by the identified resident at a family conference. The progress note in PointClickCare (PCC) for the resident stated that the family was happy with the care and a few concerns were brought forward and were addressed. In an interview with the resident they were unable to recall the incident and stated that the staff had been good.

In an interview with a staff member regarding alleged abuse, they said that they were present at the family conference and believed at the time that it was possible that abuse had occurred. This staff member also said that they would have reported to the DOC immediately or the next time that they saw them.

In interviews with the Administrator they stated that the DOC became aware of the incident after the family conference and agreed that there was a gap in reporting to the Director. The Administrator explained that the resident's family member and their Power Of Attorney (POA) went away and the DOC was unable to reach them for some time.

Record review of the policy titled Prevention of Abuse and Neglect last reviewed November 2012, stated that each employee must immediately report suspicions of abuse to their Supervisor, Charge Nurse, DOC or Administrator and Appendix A: Table 1 titled LTCHA Section 24(1) - Reporting Certain Matters to the Director stated that "all alleged abuse by anyone was to be reported the MOHLTC immediately within business hours".

In further interviews with the Administrator they stated that the Prevention of Abuse and Neglect policy last reviewed November 2012, the MOHLTC decision trees and

Appendix A were used and followed in the home related to reporting abuse and the Administrator agreed that the incident of alleged abuse expressed by the resident at the annual family conference was not reported to the MOHLTC immediately.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that the alleged abuse of a resident by a staff member had occurred or may have occurred and the suspicion and the information upon which it was based upon was immediately reported to the Director. [s. 24. (1)]

2. A Critical Incident System (CIS) Report related to the alleged abuse of a resident by another resident was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date and time, by the Director of Care (DOC). The CIS stated that this incident occurred on a statutory holiday and the MOHLTC after hours pager was not contacted.

The incident note in PointClickCare (PCC) for the resident, and the home's investigation records documented that a staff member had called the DOC at their home at a specific date and time, to report that a resident had been physically aggressive towards another resident. This resident was totally dependent on staff for all care and mobility.

In interviews with registered staff members they stated that their role was to report any alleged abuse to the DOC immediately and they did not complete any mandatory reporting to the MOHLTC either by initiating a CIS report or by calling the after hours pager. They stated that this was the role of the DOC.

In further interviews with the Administrator they stated that they and the DOC did not have computer access to the MOHLTC mandatory reporting system from home and that unless an incident, that may include alleged abuse, was considered "major" they would not come in to the home to complete the CIS report and would wait until the next business day. The Administrator agreed that the registered staff did not submit CIS reports to the MOHLTC and further explained that the DOC would complete the report to the MOHLTC, or the Administrator in their absence, on the next business day if the incident occurred after hours or on a weekend.

Record review of the policy titled Prevention of Abuse and Neglect last reviewed November 2012, stated that each employee must immediately report suspicions of abuse to their Supervisor, Charge Nurse, DOC or Administrator and that the

MOHLTC decision trees were to be used as a guide related to the time frames to report alleged abuse which included "via the after hours contact number" and/or the Critical Incident System (CIS) during business hours. Appendix A: Table 1 titled LTCHA Section 24(1) - Reporting Certain Matters to the Director stated that "all alleged abuse by anyone was to be reported the MOHLTC immediately" within business hours and "by the after hours pager at all other times including statutory holidays".

The Administrator stated that the behaviour of the identified resident was "scary". The Administrator also said that they were aware of the after hours pager and thought that the DOC may have called in the past. The Administrator agreed that the after hours pager was not called and the incident was not immediately submitted to the Director.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by another resident had occurred or may have occurred was immediately reported to the Director. [s. 24. (1)]

3. A Critical Incident System (CIS) Report related to the alleged abuse of two residents by a staff member was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date and time, by the Director of Care (DOC). The critical incident was documented as occurring on a specific date and time.

In an interview with the identified staff member, they stated that they were working the night shift, when they were told by the registered staff who was in charge to leave the floor and go home. The home’s investigation notes showed that the registered staff member in charge sent an email to the Director of Care (DOC) on a specific date and time. In an interview with Registered Nurse (RN), who was on-call on at the time, they stated that they had directed the registered staff member to immediately contact the DOC as they did not have the DOC's home number at home.

Record review of the policy titled Prevention of Abuse and Neglect last reviewed November 2012, stated that each employee must immediately report suspicions of abuse to their Supervisor, Charge Nurse, DOC or Administrator and that the MOHLTC decision trees were to be used as a guide related to the time frames to report alleged abuse which included "via the after hours contact number and/or the Critical Incident System (CIS) during business hours". Appendix A: Table 1 titled

LTCHA Section 24(1) - Reporting Certain Matters to the Director stated that "all alleged abuse by anyone was to be reported the MOHLTC immediately by initiating the CIS within business hours Monday – Friday 8am-5pm".

In further interviews with the Administrator they stated that the expectation was that all allegations of abuse be reported to the MOHLTC immediately and agreed that the alleged incident of abuse was not reported to the MOHLTC on time.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that the alleged abuse of two residents by a staff member was immediately reported to the Director.

The severity of the issue was minimal harm, the scope of the issue was widespread and the home had a history of multiple unrelated non-compliance. [s. 24. (1)] (633)

2.
(633)

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

Dec 29, 2017

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

(A1)(Appeal/Dir# DR#074)
NOTE: This order has been altered to reflect a decision of the Director on a review of the Inspector's order. The Directors review was completed on 09/11/2017.

The licensee shall ensure that the policy to promote zero tolerance of abuse and neglect of residents is complied with. Specifically, the licensee shall ensure:

1. That the procedures within the policy for investigating alleged, suspected or witnessed abuse and neglect of residents is complied with.

2. That an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it.

3. That at least once in every calendar year, a written evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and the changes and improvements required are documented.

4. That the results of the analysis of every incident of alleged abuse is considered in the annual evaluation and that changes and improvements to prevent reoccurrence are promptly implemented.

5. That there is a written record of the evaluation of the policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents that includes the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented.

6. That all staff receive annual training on the policy to promote zero

tolerance of abuse and neglect of residents.

The Licensee shall do the following for achieving compliance with LTCHA, s. 20 (2) and the Regulation, section 96:

1. Undertake a comprehensive review of the Home's policies to promote zero tolerance of abuse and neglect of residents, and make revisions where required, in order to ensure compliance with all elements of the legislative and regulatory requirements.
2. This review and revision shall also include the following, at a minimum:
a. clearly set out what constitutes abuse and neglect by ensuring definitions of abuse are aligned with legislative definitions;
b. provide clear direction on timelines for mandatory reporting; and
c. a description of the Home's process to ensure that "a person" (i.e. anyone) who has reasonable grounds to suspect any of the mandatory reporting elements have occurred must immediately report the matter to the Director (under the LTCHA).

Grounds / Motifs :

1. The licensee has failed to ensure that without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that the written policy to promote zero tolerance of abuse policy is complied with.

Record review of the policy titled Prevention of Abuse and Neglect, last reviewed November 2012, stated that:

-Abuse of a resident was defined as "any action against a resident, that the person knew or ought to have known would cause, or reasonably be expected to cause, harm to the resident's safety or well-being".
-"The charge Registered Nurse (RN) would follow the Investigations of Allegations of Abuse policy to determine if there were reasonable grounds to suspect that the abuse had occurred and they would also initiate the initial investigation upon receiving a report of an allegation of abuse".
-"All staff interviewed were to write and sign statements" and these "shall be retained on file".
-"The supervisor to whom the abuse was reported to should prepare a written incident report that contained who was involved, written signed statements from all

witnesses, what was observed, when the incident happened, any related events leading up to the incident and the status which included the impact of the abuse, assessment for injury and any treatments required, follow-up assessments" and "future prevention was to be included by documenting their opinion of ways the event could have been prevented".
-"Each employee that suspected abuse of a resident must immediately report the suspicions to their supervisor and the applicable reporting of abuse decision trees from the MOHLTC would be used to determine the reporting criteria and time frames".
-It was the "responsibility of management to ensure that a thorough investigation was completed and acted on in accordance with the Investigation of Allegation of Abuse policy".
- Appendix A: Table 1 titled LTCHA Section 24(1) - Reporting Certain Matters to the Director stated that "all alleged abuse by anyone was to be reported the MOHLTC immediately by any person who was aware of an incident of abuse" and they were to also "initiate the CIS within business hours or by phoning the after hours pager at all other times and statutory holidays".
-"The abuse policy would be reviewed with all employees and volunteers annually".
-"An analysis of every incident would be completed and included in the annual evaluation of the Prevention of Abuse and Neglect program at least once in every calendar year to determine the effectiveness of the policy".

Three Critical Incident System (CIS) Reports related to the alleged abuse of residents were not submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the Director of Care (DOC) immediately and the MOHLTC after hours pager was not called when appropriate.

Record review of the the home's investigation records that were provided by the Administrator did not include the initial investigations and written documentation that was to be completed by the registered staff in charge at the time of the incident as stated in the Prevention of Abuse and Neglect policy last reviewed November 2012.

In interviews with staff members they said that they were to report alleged abuse to their supervisor and that the DOC would complete the mandatory reporting to the MOHLTC. An RN said that if the incident occurred on a weekend or after hours then they would be considered the supervisor in the building and only if they thought the incident was abuse would they notify the DOC or Administrator and this depended upon who was on call that weekend. They also said that the expectation was that

abuse was reported right away to registered staff and the registered staff would take the statements right away as people don't remember. The RN further stated that they may ask the staff to write it down and if they felt that abuse has occurred and explained that their role was to document the incident and the DOC and Administrator were responsible to complete the investigation. They also further stated that they would send an email to the Administrator and DOC as their documentation of the incident and they would not complete any reporting related to abuse to the Ministry as the DOC and/or the on call manager was responsible for this as well. Another RN said that they did not complete abuse investigations or paper work other than possibly risk management and agreed that they do not complete the mandatory CIS reports to the MOHLTC as this was the role of the DOC.

In an interview with the Administrator they said that they and the DOC were the lead for the Prevention of Abuse and Neglect policy review and they stated that they did not have an Abuse program. The Administrator was unable to provide the "Investigation of Allegation of Abuse Policy" stated in the Prevention of Abuse and Neglect policy, lasted reviewed November 2012 as the process for alleged abuse investigations that was to be followed by the charge RN. The Administrator said that the home does not use this and explained that the registered staff would usually just send an email or call them at home, if the incident occurred after hours. The Administrator also said that the DOC completed the mandatory CIS reports to the MOHLTC, or the Administrator in their absence or when on-call, as the registered staff were not trained. In further interviews, the Administrator explained that they did not have computer access to the mandatory reporting system from their home and stated that unless the situation was a case of severe abuse they would not come in to the home as this could wait until Monday. When asked if there was a situation of alleged verbal abuse the Administrator stated that this too would be addressed by the DOC on the next business day if the incident occurred after hours.

When the Administrator was asked for the written evaluation of effectiveness of the Prevention of Abuse and Neglect policy and documentation of the changes made to this policy, the Administrator was unable to provide a written evaluation and agreed that the policy had not been evaluated since 2012.

Record review of the staff education materials related to Prevention of Abuse and Neglect for 2016 with the Administrator, they said that the Abuse policy was not included in the 2016 educational booklet that was reviewed by staff at the annual in-service training.

In a telephone interview with the Administrator they said that that the staff education for 2016 did not include reviewing the Prevention of Abuse and Neglect policy as they thought that the College of Nurse of Ontario (CNO) abuse modules provided to staff online were sufficient.

The licensee has failed to ensure that without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that the written policy to promote zero tolerance of abuse was complied with.

The severity of the issue was minimal harm/risk or potential for actual harm/risk, the scope of the issue was widespread and the home had a history of multiple unrelated non-compliance. [s. 20. (1)] (633)

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

Dec 29, 2017

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

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

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

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

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

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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 9 day of November 2017 (A1)(Appeal/Dir# DR#074)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SHERRI COOK - (A1)(Appeal/Dir# DR#074)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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Service Area Office / Bureau régional de services : London