Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 22, 2019	2019_770178_0001	026696-17, 002629-18, 010601-18, 012296-18, 021952-18, 022664-18, 026802-18	Critical Incident System

Licensee/Titulaire de permis

Arnprior Regional Health
350 John Street North ARNPRIOR ON K7S 2P6

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

The Grove, Arnprior and District Nursing Home
275 Ida Street North ARNPRIOR ON K7S 3M7

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

SUSAN LUI (178)

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 16, 17, 18, 21, 22, 23, 24, 25, 28, 29, 30, 31, 2019

The following Critical Incident Logs were inspected:
002629-18 (CIR #2699-000001-18), regarding an allegation of staff to resident neglect
022664-18 (CIR #2699-000006-18), regarding an allegation of staff to resident abuse and neglect
026696-17 (CIR #2699-000004-17), 010601-18 (CIR #2699-000002-18), 012296-18 (CIR# 2699-000003-18), 021952-18 (CIR #2699-000005-18), and 026802-18 (CIR #2699 -000007-18), all regarding resident falls with injuries.

During the course of the inspection, the inspector(s) spoke with residents, family of a resident, Personal Support Workers (PSWs), former PSWs, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Resident Care Coordinator (RCC), Director of Care (DOC), Infection Prevention and Control Coordinator, and the Vice President of Patient/Resident Services/Chief Nursing Executive (CNE).

During the course of the inspection, the inspector also observed residents, resident care, resident care areas, and staff/resident interactions, reviewed residents' health records, including assessments, plans of care and progress notes, and reviewed home records, including internal incident reports, investigation notes, and home policies.

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

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

This non-compliance is in regards to Log #022664-18 (CIR #2699-000006-18).

The LTCHA defines verbal abuse as any form of verbal communication of a belittling or degrading nature which may diminish the resident's sense of well-being, dignity or self worth made by anyone other than a resident.

Critical Incident Report (CIR) #2699-000006-18, submitted by the licensee on an identified date, indicated that on the previous day, several Personal Support Workers (PSWs) reported concerns with the care provided by PSW #124 while working the night shift the previous week. The PSWs reported that PSW #124 had made comments to residents which included "don't be lazy", "I'm not putting on your fu…ing bra", and "you wanted up, you can stay up".

During an interview with Inspector #178 on January 22, 2019, PSW #106 indicated that when resident #011 attempted to get out of bed repeatedly at night, PSW #106 witnessed PSW #124 say to the resident, words to the effect of "if you get out of bed one more time then Im gonna get you up into your chair and you'll be up all night". PSW #106 indicated that they witnessed PSW #124 make this threat to resident #011 on more than one occasion, when PSW #106 worked night shifts with PSW #124.

During an interview with Inspector #178 on January 23, 2019, PSW #105 indicated that they often witnessed PSW #124 curse and speak negatively about the residents in the residents' presence. PSW #105 indicated that PSW #124 made the following comments to co-workers while in the resident's presence:
-"I'm not F-ing doing that" regarding assisting with a part of the resident's care
-"they're always playing in their SH*T" and
-"I'm tired of all this pulling, they don't F-ing help anyways".
PSW #105 also indicated that PSW #124 said to resident #011 when the resident tried to get out of bed, "you're not F-ing getting up so you can stay there".

Inspection indicated that the verbal abuse took place over several shifts, and was not immediately reported by the PSWs who witnessed it. Once the verbal abuse was reported to the Director of Care, PSW #124 was removed from duty while an internal investigation took place. PSW #124 is no longer employed by the licensee. [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 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. 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 the person who had reasonable grounds to suspect that abuse of a resident by anyone occurred, did immediately report the suspicion and the information upon which it was based to the Director under the Long-Term Care Homes Act (LTCHA).

This non-compliance is in regards to Log #002629-19 (CIR #2699-000001-18)

On an identified date, the licensee submitted Critical Incident Report (CIR) #2699-000001-18 to the Ministry of Health and Long-Term Care (MOHLTC), indicating that in

the morning two days prior, a report of alleged neglect was brought forward by PSW #104. According to the CIR, PSW #104 reported to the registered nursing staff on duty that the staff on the previous shift had indicated that resident #002 would likely be very wet because the resident had not been changed or toileted during the night. The CIR indicated that registered nursing staff informed the home's Director of Care (DOC) of the neglect allegation on the same morning that PSW #104 reported it. The CIR indicated that the neglect allegation was first reported to the Director under the LTCHA two days later at 1757h.

During an interview with Inspector #178 on January 18, 2019, the DOC indicated that they were informed of the neglect allegation on the same morning that PSW #104 reported it, but the DOC did not report the allegation to the Director under the LTCHA until two days later. The DOC indicated awareness of the requirement for immediate reporting of any suspicion of neglect to the Director under the LTCHA. The DOC indicated that they did not report immediately because they were not sure the incident constituted neglect.

Review of a progress note for resident #002, written by the DOC on the day that PSW #104 reported the neglect allegation, indicated that the DOC called and spoke to resident #002's substitute decision maker (SDM) to inform them of the incident. In the progress note the DOC referred to the incident as the mandatory incident being reported regarding the possibility of neglect of resident #002 by staff members during the night shift. [s. 24. (1)]

2. This non-compliance is in regards to Log #022664-18 (CIR #2699-000006-18).

On an identified date, the licensee submitted Critical Incident Report (CIR) #2699-000006-18 to the Ministry of Health and Long-Term Care (MOHLTC), indicating that on the previous day, several PSWs informed the Director of Care of concerns they had with the care provided by PSW #124. The PSWs alleged that PSW #124 was rough while providing care to various residents, turning residents by grabbing their wrist and arms, removing residents' clothing with excessive force, and pulling blankets back with force. The CIR also indicated that the PSWs had alleged verbal abuse and neglect by PSW #124, indicating that PSW #124 made comments such as "come on don't be lazy", "spread your legs", "I'm not putting on your fu..ing bra", "I'm not changing her, she'll be awake all night", "You wanted up, you can stay up" and that PSW #124 refused to toilet residents when requested.

During an interview with Inspector #178 on January 18, 2019, the DOC indicated that during a PSW meeting on an identified date, several PSWs brought forward concerns regarding the care provided to various residents by PSW #124. Those concerns included rough care and verbal abuse. The DOC indicated that the DOC first reported the allegations of abuse to the Director under the LTCHA in CIR #2699-000006-18, submitted at 2211h on the day after the PSWs first reported the allegations. The DOC indicated awareness of the requirement for immediate reporting of suspicion of abuse, and could not explain why the CIR was not submitted until the following evening. Further, the DOC indicated that the PSWs who reported their concerns of abuse had indicated that the incidents took place during the previous three weeks. The DOC indicated that they informed the PSWs who reported the allegations of abuse that they should have reported their concerns to the DOC immediately.

During an interview with Inspector #178 on January 22, 2019, PSW #106 indicated that in the summer of 2018, they observed PSW #124 providing rough care to resident #006. PSW #106 indicated that they did not report their concerns about the rough care to the administration or the MOHLTC immediately, and waited up to a month before reporting their concerns to the DOC. PSW #106 indicated that they did not report the concerns immediately because they were not sure that rough care constituted abuse.

During an interview with Inspector #178 on January 22, 2018, PSW #107 indicated that they observed PSW #124 roughly undressing resident #004, and considered this care to be abusive to the resident. PSW #107 indicated that they did not report this incident to the MOHLTC or the home's administration immediately, and waited less than a month before reporting it to the DOC. PSW #107 indicated awareness that the incident should have been reported right away to their supervisor or the MOHLTC.

During an interview with Inspector #178 on January 23, 2019, PSW #105 indicated that in the summer of 2018, they observed PSW #124 roughly dress and undress resident #006, roughly roll resident #008 by grabbing their wrist, and roughly roll resident #010 by forcefully grabbing their wrist and calf. PSW #105 further indicated that they observed PSW #124 speak negatively about residents and use foul language, both in front of the residents. PSW #105 indicated that they considered PSW #111's behaviour to be abusive, but they did not report their concerns to the MOHLTC or the home's administration immediately, and instead waited three to five days before reporting their concerns to the DOC. PSW #105 indicated that if they reported their concerns immediately, then PSW #111 would know who had reported them, and PSW #105 feared that PSW #124 would retaliate in some way.

As such, the licensee has failed to ensure that the persons who had reasonable grounds to suspect that abuse of a resident by anyone occurred, did immediately report the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the person who has reasonable grounds to suspect that abuse of a resident by anyone occurred, does immediately report the suspicion and the information upon which it was based to the Director under the Long-Term Care Homes Act (LTCHA), to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff have received retraining annually relating to the home's policy to promote zero tolerance of abuse and neglect of residents.

Review of 2017 and 2018 training records for PSWs #105, #106, #112, #113, and #124, indicated that these staff members did not receive annual re-training relating to the home's policy to promote zero tolerance of abuse and neglect of residents.

During an interview with Inspector #178 on January 23, 2019, the DOC indicated that staff receives computer based re-training annually relating to the Resident's Bill of Rights, the duty to make mandatory reports under section 24, the whistle-blowing protections, as well as training regarding types of abuse and any aspect with regards to the LTCHA legislation and requirements around the legislation. However annual re-training of all staff does not include review of the licensee's own policy to promote zero tolerance of abuse. The DOC indicated that some staff members have received annual re-training relating to the home's policy to promote zero tolerance of abuse, via skills days or staff meetings, however there is no certainty that every staff member has received that re-training annually. [s. 76. (4)]

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 staff receive retraining annually relating to the home's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #4: 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 has failed to ensure that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences.

Interview between Inspector #178 and the Vice President (VP) of Patient/Resident Services/Chief Nursing Executive (CNE), on January 28, 2019, indicated that the home's policy to promote zero tolerance of abuse and neglect of residents is not evaluated for effectiveness annually. The VP of Patient/Resident Services/CNE indicated that if there was an occurrence of abuse or neglect and it was felt in looking at the policy that there was a gap, then that would be the extent of the evaluation. The VP of Patient/Resident Services/CNE indicated that the policy was evaluated in May of 2014, and then again in December 2018.

Interview with the DOC on January 28, 2019, indicated that the home's policy to promote zero tolerance of abuse and neglect of residents was last evaluated on December 13, 2018, but does not appear to have been evaluated in the 2015, 2016 or 2017 calendar year.

Inspector #178 reviewed the licensee's policy titled Zero Tolerance of Abuse and Negect, #VI-G-10.00. On page 14 of 14, the policy indicates that the original date was March 2007 and the policy review dates are May 2014 and December 2018. [s. 99. (b)]

Issued on this 22nd day of February, 2019

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

Original report signed by the inspector.