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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 2, 2015	2015_380593_0011	S-001122-15	Critical Incident System

Licensee/Titulaire de permis

MANITOULIN CENTENNIAL MANOR HOME FOR THE AGED BOARD OF MANAGEMENT
70 Robinson Street Postal Bag 460 LITTLE CURRENT ON P0P 1K0

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

MANITOULIN CENTENNIAL MANOR HOME FOR THE AGED
70 ROBINSON STREET POSTAL BAG 460 LITTLE CURRENT ON P0P 1K0

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

GILLIAN CHAMBERLIN (593)

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): March 16 - 19, 2015.

A Compliance Order was also served as a result of this CI inspection, however this is captured under follow-up inspection #2015_380593_0005 as it is linked to a past due order under the same legislation.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nursing Staff, Personal Support Workers (PSW), residents and family members.

The inspector also observed the provision of care and services to residents, observed staff to resident Interactions, observed resident to resident Interactions, observed residents' environment, reviewed resident health care records, reviewed staff training records and reviewed home policies.

The following Inspection Protocols were used during this inspection:
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	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.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is in place a written policy to promote zero

tolerance of abuse and neglect of residents, and that the policy is complied with.

A Critical Incident was submitted to the Ministry of Health and Long-Term Care in 2015, in relation to reported abuse by a PSW towards several residents in the home. During the home’s investigation into the alleged abuse by #s-102, it was identified by resident #001 that #s-109 had previously provided rough care and that they reported this to the previous Administrator. During this investigation, it was also reported by #s-108 that residents #005 and #009 had previously complained about #s-109 and their emotional abuse toward the two residents. #S-108 advised that they had reported this to the RN on duty, #s-110 at the time of the incident.

During an interview with Inspector #593 March 17, 2015, the Administrator and DOC said that they assumed that the previous Administrator had dealt with the two allegations of abuse brought forward involving #s-109. At that time, they had not taken these concerns further either by investigation or reporting to the MOHLTC. However, they were able to locate documentation by the former Administrator relating to the two incidents as follows:

• Regarding the first incident that occurred, a comprehensive investigation was not completed or documented including interviewing of the residents and staff members involved. The residents' SDMs were not contacted regarding the abuse allegations and the incident was not reported to the MOHLTC. The accused staff member was not disciplined and they were not removed from the work schedule, pending the investigation as per the home's policy.

• Regarding the second incident that occurred, a comprehensive investigation was not completed or documented including interviewing of the staff members involved. The resident's SDM was not contacted regarding the abuse allegations and the incident was not reported to the MOHLTC. The accused staff member was not disciplined and they were not removed from the work schedule, pending the investigation as per the home's policy.

A review of the home’s policy #OPER-02-02-04 Resident Abuse- Staff to Resident, dated November 2013, found:

• All reported incidents of abuse will be objectively, thoroughly, promptly, and accurately investigated and upon notification of suspected or witnessed abuse the Administrator / DOC are to initiate an internal investigation and complete a preliminary report before going off duty and ensure comprehensiveness of all investigative documentation.

• Upon being notified of suspected or witnessed abuse, the Administrator or DOC are to remove the employee from the work schedule, pending investigation.
• The residents POA's are to be notified within 12 hours of becoming aware of any alleged, suspected or witnessed incident of abuse and then promptly notified upon completion of the investigation with the results of the investigation.
• The suspected or witnessed abuse is also to be immediately reported to the MOHLTC Director through the Critical Incident Reporting System / after-hours pager.

During an interview with Inspector #593 on March 18, 2015, #s-108 said that approximately one year previously, residents #005 and #009 made a complaint to them about #s-109 and their emotional abuse when providing care. #S-108 advised that they reported the allegations to the RN on duty who took the allegations to the Administrator. #S-108 confirmed that they were never approached by the home to discuss the allegations further.

During an interview with Inspector #593 on March 18, 2015, resident #005 said that they made a complaint about #s-109 to another staff member in the home, the staff member advised that they would report the complaint to the Administrator. They further added that the Administrator did not speak with them about the complaint nor did they contact their SDM about the incident.

During an interview with Inspector #593 on March 18, 2015, resident #001 said that previously #s-109 was always rough when providing care and was rude when speaking with them. They further advised that they informed the on-duty RN about this who informed the Administrator. Resident #001's SDM was present at the time of the interview and they told the inspector that they were never informed about this by the staff of the home and that this is the first they are hearing about the incident.

Non-compliance was previously identified under inspection 2013_395163_0006 pursuant to LTCHA, 2007 S.O. 2007, c. 8, 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.

As per the home's written policy #OPER-02-02-04 Resident Abuse- Staff to Resident, dated November 2013, the licensee failed to comply with numerous sections of the policy including the reporting of incidents of abuse or alleged abuse to the MOHLTC, failing to conduct a thorough investigation, failing to remove the accused employee from the work

schedule pending investigation and failing to notify resident SDMs with the abuse allegations and the results of the investigation. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that every aspect of the home's policy #OPER-02-02-04 Resident Abuse- Staff to Resident, dated November 2013 is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, or that is reported to the licensee, is immediately investigated.

A Critical Incident was submitted to the Ministry of Health and Long-Term Care in 2015, in relation to reported abuse by a PSW towards several residents in the home. During the home's investigation into the alleged abuse by #s-102, it was identified by resident #001

that #s-109 had previously provided rough care and that they reported this to the previous Administrator. During this investigation, it was also reported by #s-108 that residents #005 and #009 had previously complained about #s-109 and their verbal and emotional abuse toward the two residents. #S-108 said that they had reported this to the RN of duty, #s-110.

During an interview with Inspector #593 on March 17, 2015, the Administrator and DOC advised that they assumed that the previous Administrator had dealt with the two allegations of abuse brought forward involving #s-109. At this time, they had not taken these concerns further either by investigation or reporting to the MOHLTC.

A review of #s-109's employment file found no record or mention of the two incidents of alleged abuse made against the staff member however, after the previous interview the Administrator and DOC were able to locate documentation by the former Administrator regarding the two incidents of abuse allegations toward #s-109 as follows:

Incident One

• A note was left for the Administrator by #s-110:

Please read the attached progress notes. Residents #005 and #009 have raised some concerns about #s-109.

The Administrator added a handwritten note to this:

Met with #s-109 and Union Rep, reviewed contents of these notes with staff member.

The progress notes documented by #s-110, included numerous examples of emotional abuse and neglect by #s-109 towards residents #005 and #009 including #s-110 telling resident #009 that their "skin was going to fall off" when requesting additional foot cream and #s-110 telling resident #009 "there's the bathroom" when the resident requested toileting assistance.

Incident Two

• The Administrator spoke with resident #001 regarding the issue. The resident advised that #s-109 was rough when changing them in the morning and would not speak to them. The Administrator advised them not to tolerate this behaviour and to report this kind of

behaviour immediately to the on-duty RN. The Administrator told the resident that they would speak to #s-109 about the matter.
• The Administrator spoke with #s-102 who works with #s-109. #S-102 had never had any residents complain about #s-109 or noticed them being rough at any time.
• The Administrator spoke with #s-109 on the phone about the alleged abuse. The staff member was informed that a complaint had been made about rough care and that it was considered abuse. Any further complaints would be dealt with as discipline as we have zero tolerance for abuse.

A review of the home's policy #OPER-02-02-04 Resident Abuse- Staff to Resident, dated November 2013, found that all reported incidents of abuse will be objectively, thoroughly, promptly, and accurately investigated and upon notification of suspected or witnessed abuse the Administrator / DOC are to initiate an internal investigation and complete a preliminary report before going off duty and ensure comprehensiveness of all investigative documentation including:

• Internal Incident Reporting System: Resident Incident Report
• Investigative Notes: Document pertinent details of the investigation, actions taken during the investigation and any actions taken as a result of the outcome of the investigation and kept in a secure location. Ensure that all statements from witnesses are written and signed by the witness, if possible or by the Administrator.

Regarding the second incident, no further residents or staff members were interviewed regarding these allegations. The residents' SDM was not contacted nor was this incident reported to the MOHLTC. An internal incident report was not completed nor was a comprehensive investigation completed or documented, or any statements from staff members signed by either the staff member or the Administrator.

Regarding the first incident, no residents or staff members were interviewed regarding these allegations including the two residents who initially reported the allegations against #s-109. The resident's SDMs were not contacted nor was this incident reported to the MOHLTC. An internal incident report was not completed nor was a comprehensive investigation completed or documented, or any statements from staff members signed by either the staff member or the Administrator.

During an interview with Inspector #593 on March 18, 2015, #s-108 advised that approximately over one year previously, residents #005 and #009 made a complaint to them about #s-109 and their inappropriate behaviour when providing care. #S-108

advised that they reported the allegations to the RN on duty who took the allegations to the Administrator. #S-108 confirmed that they were never approached by the home to discuss the allegations further.

During an interview with Inspector #593 on March 18, 2015, resident #005 said that they made a complaint about #s-109 to another staff member in the home, the staff member advised that they would report the complaint to the Administrator. Resident #005 further added that the Administrator did not speak with them further about the complaint.

During an interview with Inspector #593 on March 18, 2015, resident #001 said that previously #s-109 was always rough with providing care and was rude when speaking with them. They further advised that they informed the on-duty RN about this who informed the Administrator. Resident #001's SDM was present at the time of the interview and they told the inspector that they were never informed about this by the staff of the home and that this is the first they are hearing about the incident.

During an interview with Inspector #593 on March 19, 2015, the DOC advised that regarding the allegations of abuse by #s-109 towards residents in the home, they have now submitted a CI and they are beginning an investigation today. The DOC and the Administrator were concerned with the allegations and the DOC acknowledged that there were issues with the investigation previously undertaken by the former Administrator.

The licensee was aware of allegations of abuse by #s-109 towards three residents in the home. The response by the home did not include a thorough and documented investigation, notification of SDMs, compliance with numerous sections of the home's policy or disciplinary action towards the accused staff member. [s. 23. (1) (a)]

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 ensuring that, upon being made aware of abuse or allegations of abuse toward a resident, a comprehensive investigation is immediately commenced as per the home's policy #OPER-02-02-04 Resident Abuse- Staff to Resident, dated November 2013, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to immediately report the suspicion and the information upon which it is based to the director: abuse of a resident by anyone that resulted in harm or risk of harm to the resident.

A Critical Incident (CI) was submitted to the Ministry of Health and Long-Term Care in regards to an incident of alleged physical abuse reported by #s-103. It was reported that #s-102 provided rough care towards numerous residents in the home. The CI was submitted on a particular day in 2015 however the alleged abuse was reported to have occurred approximately two months earlier than when the CI was submitted.

During an interview with Inspector #593, #s-103 reported that at the time of the incident they had just commenced employment in the home and they had one orientation shift with #s-102. They further advised that during this shift, they witnessed #s-102 provide rough care to numerous residents and they reported this to the night shift on-duty Registered Nurse (RN) #s-107. #S-103 said that they later mentioned the abuse allegations to the Administrator on a particular day in 2015, as they were confused why their allegations were not investigated. At that time, the Administrator was not aware of their allegations toward #s-102.

During an interview with Inspector #593 on March 17, 2015, the Administrator said that they spoke with #s-103 a week earlier about an incident with another staff member, the Administrator suggested that #s-103 may have come forward with the abuse allegations as #s-103 was reported for something else. The Administrator was really not sure why #s-103 did not report the allegations earlier however #s-103 did advise that they had reported the allegations to the on-duty RN at the time.

A review of the home's investigation records found that registered staff #s-107 stated that #s-103 did not mention anything to them about the alleged abuse reported to them by #s-103. The Administrator and DOC informed #s-107 that they need to report any issues/concerns to them immediately going forward so that they can investigate the issue/concern.

During the home's investigation into the alleged abuse by #s-102, it was identified by resident #001 that #s-109 had previously provided rough care and that they reported this to the previous Administrator. During this investigation, it was also reported by #s-108 that residents #005 and #009 had previously complained about #s-109 and their emotional abuse toward the two residents. #S-108 advised that they had reported this to the RN of duty, #s-110.

During an interview with Inspector #593 on March 17, 2015, the Administrator and DOC said that they assumed that the previous Administrator had dealt with the two allegations of abuse brought forward involving #s-109. At this time, they had not taken these concerns further including reporting to the MOHLTC.

A review of the home's records found that two incidents of alleged abuse were reported to the previous Administrator by #s-110 and resident #001, however a review of the CI system found that neither allegation of abuse by #s-109 was reported to the MOHLTC.

A review of the home's policy #OPER-02-02-04 Resident Abuse- Staff to Resident, dated November, 2013, found that all staff are to immediately report any suspected or witnessed abuse to the Administrator, Director of Care or designate and as required by provincial legislation; MOHLTC Director.

Multiple findings of non-compliance were previously identified under inspection 2014_395151_0009 and 2013_139163_0013, pursuant to LTCHA, 2007 S.O. 2007, c. 8, s. 24. (1) (2) 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: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

The licensee received allegations of abuse by staff members towards residents in the home on three occasions. On two occasions, the allegations were not reported to the Director of the MOHLTC and on the third occasion, the Critical incident was submitted, however this was approximately two months after the alleged abuse was first reported to the home. [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 ensuring that all staff report allegations of abuse immediately as per the home's policy and that all abuse or alleged abuse of a resident is reported immediately to the Director of the MOHLTC, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker (SDM), and any other person specified by the resident are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident that has caused distress to the resident that could potentially be detrimental to their health or well-being.

A Critical Incident was submitted to the Ministry of Health and Long-Term Care in 2015, in relation to reported abuse by a PSW towards several residents in the home. During the home's investigation into the alleged abuse by #s-102, it was identified by resident #001 that #s-109 had previously provided rough care and that they reported this to the previous Administrator. During this investigation, it was also reported by #s-108 that residents #005 and #009 had previously complained about #s-109 and their emotional abuse toward the two residents. #S-108 advised that they had reported this to the RN of duty, #s-110.

During an interview with Inspector #593 on March 17, 2015, the Administrator and DOC said that they assumed that the previous Administrator had dealt with the two allegations of abuse brought forward involving #s-109. At this time, they had not taken these concerns further either by initiating an investigation or reporting to the MOHLTC.

A review of #s-109's employment file found no record or mention of the two incidents of alleged abuse made against the staff member, however after the previous interview, the Administrator and DOC were able to locate documentation by the former Administrator regarding the two incidents of abuse allegations toward #s-109 occurring at earlier dates. There was no mention in these documents of the Administrator contacting the residents' SDMs with the allegations of abuse brought forward.

A review of the home's policy #OPER-02-02-04 Resident Abuse- Staff to Resident, dated November 2013, found that within 12 hours of becoming aware of any alleged, suspected or witnessed incident of abuse that has caused distress to the resident that could potentially be detrimental to their health or well-being, notify the resident's SDM or POA.

During an interview with Inspector #593 March 18, 2015, resident #005 said that they made a complaint about #s-109 to another staff member in the home, the staff member advised that they would report the complaint to the Administrator. They further added that the Administrator did not contact their SDM about the incident.

During an interview with Inspector #593 March 18, 2015, resident #001 said that

previously #s-109 was always rough with providing care and was rude when speaking with them. They further advised that they informed the on-duty RN about this who informed the Administrator. Resident #001's SDM was present at the time of the interview and they told the inspector that they were never informed about this by the staff of the home and that this is the first they are hearing about the incident.

The licensee was aware of allegations of abuse by #s-109 towards three residents in the home. The response by the home did not include a thorough and documented investigation including notification of the resident's SDM within 12 hours after becoming aware of the abuse allegations. [s. 97. (1) (b)]

Issued on this 29th day of June, 2015

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

Original report signed by the inspector.