Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 14, 2020	2020_680687_0001	023229-19, 023233-19, 023237-19, 023241-19	Critical Incident System

Licensee/Titulaire de permis

584482 Ontario Inc.
c/o Jarlette Health Services 711 Yonge Street MIDLAND ON L4R 2E1

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

Manitoulin Lodge
3 Main Street P.O. Box 648 GORE BAY ON P0P 1H0

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

LOVIRIZA CALUZA (687), RYAN GOODMURPHY (638)

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 8 to 10, 2020.

The following intakes were inspected during this Critical Incident Systems (CIS) inspection:

Two intakes related to staff to resident neglect, and

Two intakes related to staff to resident alleged abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Co-DOC, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and their families.

The Inspectors also conducted a daily tour of the resident care areas, observed the provision of care and services to residents, reviewed relevant health care records, internal investigation notes as well as relevant policies and procedures.

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.
- **1 WN(s)**
- **1 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. 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 the staff complied with the home’s zero tolerance of abuse and neglect policy.

A Critical Incident (CI) report was submitted to the Director, regarding staff to resident neglect related to a specified action of a specified medical concern which had occurred on a specified date.

Inspector #687 reviewed the CI report, regarding resident #003 who was identified with a specified medical concern, in a specified area, on a specified date. The CI report indicated that Personal Support Worker (PSW) #104 observed resident #003 exhibited a number of specified medical concerns and had reported this immediately to Registered Nurse (RN) #102.

A review of the home’s internal investigation on a specified date, indicated that RN #102 acknowledged that resident #003 was in the specified area, on a specified date, but could not recall any immediate report from PSW #104 regarding resident #003's specified medical concerns.

Inspector #687 reviewed the resident’s specified electronic documentation records for the specified date and did not identify any documentation of resident #003’s specified medical concerns.

In an interview with PSW #104, they verified that on a specified date, they observed resident #003 in a specified area exhibiting a number of specified symptoms. The PSW further stated that they had reported this immediately to RN #102 and observed that the RN did not provide any assessment or intervention for the resident.

During an interview with the Administrator/Director of Care (DOC), they stated that based on their internal investigation on the specified date, RN #102 did not provide any assessment for resident #003 during and after a specified medical concern and that a substantiated neglect was identified regarding RN #102 towards resident #003. [s. 20. (1)]

2. Two CI reports were submitted to the Director related to an incident of alleged staff to resident abuse. The reports outlined the interactions of RN #102 towards resident #001 and resident #002 during their shift.

Inspector #638 reviewed a document that was initiated on a specified date, which

indicated that resident #002 approached RN #108 to report concerns about RN #102.

The investigation notes identified that the Administrator/DOC met with resident #001 and resident #002 on a specified date. The notes outlined the alleged abuse and the interactions between the residents and RN #102. The Inspector identified in the meeting notes between RN #102 and management that the RN was unable to recall their actions or the events in which they worked and in which the allegations were related.

The Inspector interviewed resident #001 and resident #002 and their interactions with RN #102. The residents described RN #102's response towards them in which they felt intimidated and fearful to request specified care needs.

During an interview with Inspector #638, RN #107 indicated that whenever an incident of abuse or neglect was suspected or reported to them, they would immediately report these concerns to management in the home or via phone if after hours.

The home's policy titled "Resident Rights, Care And Services – Abuse – Zero-Tolerance Policy for Resident Abuse and Neglect – Version 3" last revised April 25, 2019, defined emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that was performed by anyone other than a resident.

Inspector #638 interviewed the Co-DOC, who indicated that they responded to resident #002's concerns on a specified date. Based on the resident's account, the Co-DOC indicated they felt that RN #102's interactions with the residents were not acceptable and that the residents were fearful to request for their specified care needs.

In an interview with Inspector #687, the Administrator indicated that the outcome of the internal investigation regarding resident #001 and resident #002's report of abuse regarding RN #102's action towards the residents were substantiated.

3. A CI report was submitted to the Director regarding an alleged improper care of staff during resident #001's complaint of a specified medical concern on a specified date.

Inspector #687 reviewed the CI report, regarding resident #001 who had a complaint of a specified medical concern on a specified date and that RN #102 was notified.

A review of the home's internal investigation on a specified date which indicated that RN #102 could not recall the date resident #001 had a specified medical concern but indicated that they had taken a specified action and that it was recorded.

Inspector #687 reviewed the resident's electronic documentation records for the specified date and did not identify any record documented by RN #102 regarding resident #001's specified medical concern incident.

During an interview with resident #001, they stated that they had experienced a number of specified medical concerns and resident #002 had called a staff member whom they identified as RN #102.

In an interview with resident #002, they stated that resident #001 told them of their specified medical concerns and that they had reported this to RN #102. Resident #002 stated that they heard RN #102 ask resident #001 about their specified medical concerns in which the RN told resident #001 a specific action. Resident #002 further stated that the RN left and never came back.

During an interview with the Administrator, they stated that they spoke to RN #102 regarding resident #001's report of a specified medical concern on a specified date. The Administrator further stated that based on their internal investigation, RN #102 did not provide any assessment to resident #001 during and after their specified medical concerns and that a substantiated neglect was identified regarding RN #102 towards resident #001. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's policy to promote zero tolerance of abuse and neglect is complied with, to be implemented voluntarily.

Issued on this 16th day of January, 2020

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

Original report signed by the inspector.