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

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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 23, 2019	2019_583117_0005	018872-18, 024300-18, 027653-18	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 4) GP Inc. as general partner of CVH (No. 4) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Manoir Marochel
949 Montreal Road OTTAWA ON K1K 0S6

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

LYNE DUCHESNE (117)

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 and 18, 2019 on site in the home and on January 21, 2019 off-site

during the course of this inspection, three critical incident inspections were conducted
- log # 011872-18: a critical incident (CIS #2867-000014-18) related to an incident of a missing resident, less than 3 hours
- log # 024300-18: a critical incident (CIS 2867-000015-18) related to an alleged incident of visitor to resident abuse
- log # 027653-18: a critical incident (CIS 2867-000019-18) related to an alleged incident of staff to resident physical abuse

During the course of the inspection, the inspector(s) spoke with the home's Adminsitrator, Director of Care (DOC), the home's Extendicare Assist Nursing Consultant, several Registered Nurses (RNs), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), RAI Coordinator, administrative assistant and to several residents and resident family members.

During the course of the inspection, the inspector reviewed several resident health care records, observed the provision of resident care and services, reviewed the home's policy #RC-02-01-02 "Zero Tolerance of Abuse and Neglect: Response and Reporting", last updated April 2017, the Surge Learning Module Zero Tolerance of Abuse and Neglect Program- Staff-Itacit, the 2018 and 2017 education program and staff attendance on Zero Tolerance of Abuse and Neglect, the home's wanderguard security system and front door security.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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

- **3 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. 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 shall ensure that the policy is complied with. (Log # 027653-18)

The home has a policy #RC-02-01-02 "Zero Tolerance of Abuse and Neglect: Response and Reporting", last updated April 2017, that provides the following directives:

"Anyone who witnesses or suspects abuse or neglect of a resident by another resident, staff or other person must report the incident. The report may be made to the home and/or external authorities. At minimum, any individual who witnesses or suspect abuse or neglect of a resident must notify management immediately.
Staff must complete an internal incident report and notify their supervisor (or during after-hours the Nurse on site). The Nurse would then call the Manager on-call or General Manager/designate immediately upon suspecting or becoming aware of abuse of neglect of a resident.
Management will promptly and objectively report all incidents to external regulatory authorities, including police if there are reasons to believe a criminal code offence has been committed."

On a specified day in 2018, RPN #112 provided care to resident #002. Resident #002 had been having periods of increased agitation during an identified shift and had refused to have PSW #110 and #111 give the resident's care. During the provision of care, RPN #112 noted that resident #002 had an injury. When questioned by the RPN regarding the injury, the resident #002 continued to be agitated and responded that they did not want either PSW #110 or PSW #111 to provide their care.

RPN #112 said to the inspector that they had inquired with both PSW #110 and #111 as to resident #002's injury and reason why resident #002 was refusing to have their assistance with care. As per RPN #112, both PSWs said that the resident had been agitated during the provision of a bath done earlier that day. During the bath, resident #002 had expressed the need to be toileted. PSW #110 had tried to toilet the resident in the tub/shower room. However, the resident had refused to be toileted in the tub /shower room, became agitated and was yelling, requesting to be toileted instead in their room. PSW #111 came to PSW #110 assistance. They completed the resident's bath, dressed the resident and then PSW#110 brought the resident for toileting in their room. Later that day, when PSW #110 approached the resident for a specific care routine, resident #002 became agitated and refused care. Both PSW #110 and #111 denied knowing the cause of the resident's injury and said that neither of them had noticed any injury to the resident until the RPN brought it to their attention. As per RPN #112, PSW #111 reported to them that the resident was known to have a specific care routine that they did themselves and that they might have sustained their injury during this specific routine.

RPN #112 said that resident #002 is able to express their opinion related to their interaction with staff and the provision of care. On that specific day, resident #002 did not report to the RPN any concerns or possible abuse related to the provision of the care received that day, even when the resident was agitated and had specifically refused to have either PSW #110 and #111 assist with their care. RPN #112 said that they did not report the resident's injury to their supervisor or manager on-call nor complete an internal incident report, as per the home's zero tolerance of abuse and neglect policy, as they did not suspect that possible abuse might have occurred. [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 there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and to ensure that the policy is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible; (b) strategies are developed and implemented to respond to these behaviours, where possible; and (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. (Log # 027653-18)

Resident #002 was admitted on a specified date in 2018 with several diagnoses. The resident is identified in their plan of care as requiring one to two staff member assistance with bathing and toileting needs. Their plan identifies that the resident is on a toileting schedule.

On as specified day in 2018, resident #002 was to have their scheduled bath/shower prior to a meal service. PSW #110 assisted the resident with their bath/shower. During the provision of the bath/shower, resident #002 expressed the need to be toileted. PSW #110 toileted the resident in the tub/shower room, however the resident refused to be toileted, became agitated, was yelling and requesting to be toileted in their room. PSW #111 came to PSW #110's assistance. They toileted the resident in the tub/shower room. The resident continued to be agitated. PSW #110 and #111 then removed the still agitated resident from the toileting area and completed the resident's bath/shower. The resident was still agitated, yelling and expressing generalized discomfort. The bath/shower was completed; the resident was dried and dressed while still having periods of agitation. PSW#110 then brought the resident for toileting in their room. The resident's agitation subsided post toileting. Later that same shift, resident #002 refused

to have PSW #110 and #111 provide their care and was agitated in their presence. RPN #112 provided the resident's care. During the provision of care, RPN #112 noted an injury. The resident did not indicate how the injury might have occurred to RPN #112.

Resident #002 said to the inspector that they were very upset by the incident. The resident indicated that they are a very private person, are easily anxious and have difficulties being toileted in non-familiar settings. Resident #002 expressed their concern about staff not having listened to their needs and preferences related to being toileted in their room. Resident #002 said that they were asked by the DOC and RN #103 regarding the cause of their injury. Resident #002 said that someone had lightly touched them during the provision of the bath but did know whom it was as they were too anxious at the time of the incident.

PSW #110 and #111 said to the inspector that this was the first time that they have seen resident #002 become so agitated during the provision of care, be it either bathing or toileting. PSW #110 said that they did not stop the provision care when the resident became agitated and requested to be toileted in their room. PSW #110 and #111 said that they were focused on completing the resident's bath, even when the resident was agitated, yelling and expressing generalized discomfort. Both PSWs did not report the resident's agitation and discomfort to the unit registered nursing staff after the provision of care. PSW #110 and #111 said that they were not aware that the resident had an injury until RPN #112 brought this to their attention.

RPN #112 said to the inspector that they had not been aware of the resident's agitation and toileting issues until later that same day when the resident refused to have either PSW #110 or #111 provide their care. Resident #002 was yelling and agitated but did accept RPN #112's aide with toileting and a specific care routine. RPN #112 said that it was at that time that they noticed an injury to the resident. The RPN reported that the resident was calmer after the care had been provided but was still anxious, requesting to phone a family member as per their usual routine. RPN #112 said that they did inquire with both PSWs regarding the resident's agitation and injury. RPN #112 said that they did not do any further assessment of the resident's behaviours and cause of agitation. However they did note the resident's injury in resident #002's health care record.

DOC said to the inspector that both PSW #110 and #111 have received behavioural management training as part of the home's responsive behaviour program. The DOC said that when a resident presents with agitation and is refusing an aspect of care, staff are to stop the care, re-approach the resident when they are calm and re-direct care as

needed. They are also to bring the resident's behaviours to registered staff's attention so that these can be assessed, triggers identified and care interventions put in place based on the resident's assessed needs.

A review of the resident's health care record and plan of care in place at the time of the above incident was conducted. It does identify that resident #002 is on a toileting schedule but it does not specify that the resident has expressed their preference be toileted in their own bathroom due to their continence and anxiety needs. The plan of care also does not identify possible behavioural issues related to the resident's anxiety, bathing and toileting needs.

As such, on a specified day in 2018, PSW #110 and #111 did not reassess the provision of care to resident #002 when the resident became agitated and did not bring the resident's behaviours to registered nursing staff's attention so that these could be assessed, triggers identified and care interventions put in place based on the resident's assessed needs. [s. 53. (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, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible; (b) strategies are developed and implemented to respond to these behaviours, where possible; and (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, 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 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. (log # 027653-18)

As per O.Reg. r. 219. (1) The intervals for the purposes of subsection 76 (4) of the Act are annual intervals.

A review of the home's Zero Tolerance of Abuse and Neglect education and training was conducted. This education includes the home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports and the protections afforded by section 26 of the Long Term Care Home Act 2007 (LTCHA).

It was noted that RPN #112 has not completed their 2018 nor their 2017 zero tolerance of abuse and neglect education and training. As per the Administrator, DOC and educational records documentation, the home's management team requested at a specified time in 2018, that RPN #112 review and complete this education after an incident of suspected abuse involving resident #002. At this time, RPN #112 has not completed their zero tolerance of abuse and neglect education. [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 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, to be implemented voluntarily.

Issued on this 24th day of January, 2019

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

Original report signed by the inspector.