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
Mar 28, 2019	2019_674610_0016	032481-18, 032805-18, 003543-19	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the County of Lambton
789 Broadway Street WYOMING ON N0N 1T0

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

Marshall Gowland Manor
749 Devine Street SARNIA ON N7T 1X3

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

NATALIE MORONEY (610), KRISTEN MURRAY (731)

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 20, 21, 22, 25, 2019

The following intakes were completed during this inspection:
CIS #M613-000048-18, Log #034281-18 related to allegations of abuse from resident to resident.
CIS #M613-000049-18, Log #032805-18 related to allegations of abuse from visitor to resident.
CIS #M613-000001-19, Log #003543-19 related to falls prevention and Management.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Confidential Support Service Clerk, Registered Nurse, Behavioural Support(s), Personal Support Workers, and resident(s).

Inspector(s) completed interviews, observed resident care area's, reviewed relevant record documentation and other records as required during the inspection.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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 :

The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

The home submitted Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) regarding allegations of abuse from a visitor of the home to an identified resident.

Section 2(1) of Ontario Regulation 79/10 defines sexual abuse as (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

The home's policy titled "Prevention of Abuse and Neglect to Residents", stated in part "This policy applies to all incidents of abuse of residents, regardless of who commits the abuse. This includes any abuse committed by a staff member, volunteer, resident's family member, Substitute Decision-Maker, visitor, another resident, or any other person.". "All management that receive or have knowledge of an alleged, suspected or witnessed incident of abuse shall investigate the incident. Written statements will be obtained from all witnesses as soon as possible following the reported or witnessed alleged incident."
The home's policy Addendum titled "Abuse (reported and/or suspected) Process Checklist" stated in part "Receive complaint/concern. If it is given verbally have client fill out SCC form or use the attached addendum."

A review of the internal investigation documentation provided by the home indicated that a complaint had been received at the home regarding the identified resident and reported to the home that an individual thought to be a volunteer came up to the resident and pulled the resident's in to an inappropriate sexual action.
In an interview with the Director of Nursing and Personal Care (DONPC) when asked what the process was for documenting investigations of alleged abuse or neglect, the DONPC stated they update the CIS report as new information is discovered, and they would include factual information in the resident charts. When asked what the process is in the home for responding to complaints brought forward by residents or family members, the DONPC stated the home follows up with the family to get more information, and follows up with the department, then responds to the family with the results. When asked what the process is for documenting responses to complaints/concerns that are brought forward to the home, the DONPC stated normally documentation would be done in the progress notes.

A review of the internal investigation documentation provided by the home included a hand-written note made by an unidentified person on an unknown date, a photo of an unidentified individual, and an email with a description of the incident.

A review of the home's complaint/concern binder for indicated that there was no documented record of the complaint brought forward to the home related to the incident of alleged abuse.

In an interview with the DONPC, when asked if the home completed an investigation of the alleged incident, the DONPC # stated they believed they did. When asked where the results of the investigation were documented, the DONPC stated they were unsure.

The licensee failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

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 written policy that promoted zero tolerance of abuse and neglect of residents is complied with, 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 :

The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately report 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 risk of harm.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) regarding allegation of sexual abuse from one specific resident to another resident that resulted in a risk of harm.

Section 2(1) of Ontario Regulation 79/10 defines sexual abuse as (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

The home's policy titled "Prevention of Abuse and Neglect to Residents", which was effective stated in part: The policy applies to all incidents of abuse of residents, regardless of who commits the abuse. This includes any abuse committed by a staff member, volunteer, resident's family member, Substitute Decision-Maker, visitor, another resident, or any other person. An incident was defined as an incident which poses a potential or actual risk to the safety, security, welfare and or health of a resident or staff member. Reporting time frame for abuse immediately upon becoming aware of the

incident: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in a risk of harm to a resident.

The homes internal investigation record documentation showed that the Registered Practical Nurse (RPN) had called the SDM of resident on the receiving end of the allegations of abuse.

Record documentation showed that the PSW had witnessed the allegation of abuse between the two residents and had report that there was an early witnessed allegation of abuse on the same day observed by another PSW.

The Director of Nursing and Personal Care (DONPC) said that she was made aware of the incidents.

The DONPC said that they were aware that anyone can report abuse and acknowledge they could have called the on call line to report the abuse immediately to the Director and had failed to do so.

The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report 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 risk of harm.

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 had reasonable grounds to suspect that any of the following has occurred or may occur, 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 be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

The licensee has failed to ensure that in making a report to the Director under subsection 23 (2) of the Act, the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report was included: 2. A description of the individuals involved in the incident, including names of any staff members or other persons who were present at or discovered the incident, and 4. Analysis and follow-up action, including the immediate actions that were taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence.

The home submitted Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) regarding allegations of abuse.

Section 2(1) of Ontario Regulation 79/10 defines sexual abuse as (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

In an interview with the Community Services Supervisor (CSS) they confirmed who the individual that had been involved in the allegation of abuse.

In a review of the CIS report the name of the individual was not included in the amended report.

In an interview with the DONPC, when asked if the home updated the CIS report with the name of accused once the home was made aware, the DONPC indicated they did not.

The licensee failed to ensure that the report to the director included the name of the individual involved in the incident of abuse towards the resident and failed to include the amended the CIS report with analysis and follow-up actions.

Issued on this 2nd day of April, 2019

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

Original report signed by the inspector.