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
Mar 31, 2015	2015_295556_0006	O-001367-14, O-001164-14	Critical Incident System

Licensee/Titulaire de permis

NORTH RENFREW LONG-TERM CARE SERVICES INC.
47 Ridge Rd DEEP RIVER ON K0J 1P0

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

NORTH RENFREW LONG-TERM CARE SERVICES INC.
47 RIDGE ROAD P.O. BOX 1988 DEEP RIVER ON K0J 1P0

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

WENDY PATTERSON (556)

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): February 24, 25, 26, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Resident Services (MRS), Registered Nurses (RN), Personal Support Workers (PSW), and Residents.

The Inspector observed staff to resident interactions, reviewed resident health care records, internal investigation documentation, staff training records, the home's abuse policy, critical incident reports, and the home's standards of employee conduct documents.

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)**
- **0 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to Resident #001 as specified in the plan.

During the course of a Critical Incident Inspection a specific critical incident report was reviewed, the report indicated that on a specific date PSW #105 threw Resident #001's clothing in the laundry after Resident #001 stated he/she likes to wear his/her clothes for more than one day if they are clean. PSW #105 stated the clothes stunk, and Resident #001 smelled. The PSW proceeded to put deodorant on the resident and put on more deodorant than he/she liked to use.

In an interview PSW #104 stated that she was working the day following the incident and Resident #001 was upset because PSW #105 said that he/she needed to change his/her clothing because he/she smelled. She stated that the resident was also upset because PSW #105 put deodorant on him/her "a bunch of times" and Resident #001 tried to tell her not to do that but she went ahead anyway saying that he/she needed it.

A review of Resident #001's care plan in effect at the time of the incident stated under the focus of dressing that Resident #001 will be dressed in clothes of his/her choice and stated that Resident #001chooses what he/she will wear each day, he/she likes to reuse the same clothes if not soiled for more than one day at a time. Under the focus of personal hygiene the care plan indicated that Staff are to apply deodorant, cream and powder as per Resident #001's wishes.

In an interview the Administrator stated that PSW #105 did not follow the Care Plan as set out for Resident #001 that was in effect at the time of the incident. [s. 6. (7)]

WN #2: 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 failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was complied with.

During the course of a Critical Incident Inspection the critical incident report was reviewed, the report indicated that an incident of Staff to Resident abuse occurred on a specific date and was reported to the MOHLTC two days later.

A review was conducted of the Abuse Policy provided by the Manager of Resident Services (MRS).
The policy stated that any staff, volunteer and family member who witnesses any episode of suspected or confirmed abuse shall report, in writing, the episode immediately to any Supervisor or the Administrator. The staff person who witnesses an incident of suspected abuse of a long-term care resident, will immediately report the suspicion and the information upon which it is based, to the Director, where it involves the following:
b) abuse of a resident by anyone or neglect of a resident by the Home or staff that resulted in harm or a risk of harm to the resident.
The Supervisor or Administrator may assist the staff member to report the above information to the Director, using the method outlined which is determined by the time of day.

In an interview the MRS stated that the RN in charge on evening and night shift is considered to be a Team Leader, and there is always a Supervisor on Call. The MRS defined the Supervisor as herself, or the Administrator.

In an interview PSW #104 stated that she was working the evening following the incident. She stated that Resident #001 was upset about the incident that had taken place the previous evening. Resident #001 stated that PSW #105 said he/she needed to change because he/she smelled, and that she was rushing his/her care and was rough with him/her. The resident further stated that PSW #105 put deodorant on him/her "a bunch of times" and even though he/she tried to tell her not to she went ahead saying that he/she needed it. PSW #104 stated that she verbally reported the suspected abuse immediately to RN #102 who was the Team Leader working at the time.

A statement written by RN #102, and provided to Inspector #556 by the MRS, stated that on the evening following the incident, Resident #001 continued to be very bothered. RN #102 interviewed Resident #001 who stated that the PSW threw his/her clothing into the

laundry after he/she had told her that he/she likes to wear clothes for more than one day if they are clean. The PSW stated that they stunk and threw them in the laundry regardless. Resident #001 further indicated that the PSW stated he/she smelled and proceeded to put his/her deodorant on roughly and excessively after he/she told her that he/she does not like to use a lot. The resident was quite upset with the way he/she was treated.

A progress note on Resident #001's health care record written by RN #102 stated Resident #001 complained to PSW of care received yesterday evening. RN made aware and spoke with resident 1:1 for a detailed description of events. RN proceeded to write a note for management and left note on Manager of Resident Services desk for review.

In an interview the Administrator stated that she interpreted the incident as verbal abuse of a resident because telling a resident that he/she smelled was belittling and degrading. The Administrator further indicated that the incident was not reported to the Manager of Resident Services or the Administrator until two days after the incident took place. [s. 20. (1)]

2. During the course of a Critical Incident Inspection the critical incident report was reviewed, the report indicated that an incident of Staff to Resident verbal abuse occurred on a specific date and was reported to the MOHLTC on the following day.

In an interview RN #101 stated that on a specific evening Resident #002 was wandering and this was frustrating PSW #106 as evidenced by PSW #106's aggressive body language and harsh, frustrated tone of voice toward the resident. RN #101 stated that she did not contact the Administrator or the Manger of Resident Services (MRS) to advise them of the incident until the following day.

In an interview the Manager of Resident Services (MRS) stated that staff are trained that tone of voice, inflection, and body language can be abusive in nature even if the spoken words are not. The MRS further stated that on the morning of a specific date she received a call from RN #101 advising her of the incident that occurred the previous evening, and after an immediate internal investigation it was determined that PSW #106's harsh tone of voice and aggressive body language toward Resident #002 were intimidating in nature and therefore met the definition of verbal abuse.

Both the Administrator and MRS indicated that the Registered Staff on duty is to call one of them immediately to report any suspected or confirmed incident of abuse, which will

then be reported to the MOHLTC. [s. 20. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The Long Term Care Homes Act, 2007, c.8, s. 20. (2) states that every licensee shall ensure that at a minimum, the policy to promote zero tolerance of abuse and neglect of residents, (h) shall deal with any additional matters as may be provided for in the regulations.

Ontario Regulation 79/10, s.96 states that every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, (a)contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected.

The licensee has failed to ensure that the home's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected.

During the course of an inspection into two reported incidents of staff to resident abuse the home's policy entitled Abuse Policy was reviewed by Inspector #556. It was noted that there was no mention in the policy of procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected. [s. 96. (a)]

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, if any, and any other person specified by the resident, 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 residents health or well-being.

In the process of conducting a critical incident inspection Inspector #556 reviewed the critical incident report, which stated that the home conducted an internal investigation and determined that an incident of staff to resident verbal abuse occurred involving Resident #002. The report further stated that the Substitute Decision Maker (SDM) of the resident was not informed.

In an interview PSW #100 stated that during the evening shift on a specific date Resident #002 was wandering and PSW #106 didn't have any patience for it and spoke to Resident #002 in a very frustrated and impatient tone. PSW #100 further stated that Resident #002 became increasingly agitated and confused in response to PSW #106's tone of voice, to the point that Resident #002 was too agitated to go to bed. PSW #100 indicated that Resident #002 normally goes to bed around 8:30pm but the resident was still awake and agitated at 11pm. PSW #100 stated that she is quite certain that Resident #002's state of agitation was as a result of PSW #106's tone of voice and behavour.

In an interview the Administrator stated that the home’s internal investigation determined that without a doubt staff to resident verbal abuse had taken place from PSW #106 toward Resident #002. The Administrator further stated that the Substitute Decision Maker (SDM) of the resident was not informed. [s. 97. (1) (a)]

Issued on this 1st day of April, 2015

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

Original report signed by the inspector.