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
Nov 15, 2018	2018_703625_0024	000101-18, 000377-18, 016913-18	Critical Incident System

Licensee/Titulaire de permis

Board of Management of the District of Kenora
1220 Valley Drive KENORA ON P9N 2W7

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

Princess Court
Princess Street Box 725 DRYDEN ON P8N 2Z4

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

KATHERINE BARCA (625)

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): October 15 to 19, 2018.

The following intakes were completed in this Critical Incident System (CIS) inspection:
- Two logs related to two CIS reports for resident to resident abuse; and
- One log related to a CIS report for a fire in the home.

Follow-up inspection #2018_703625_0023 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), the Resident Assessment Instrument (RAI) Coordinator, the Administrative Clerk, the Assistant Director of Care (ADOC), the Director of Care (DOC) and the Administrator.

The Inspector also conducted observations of the care and services provided to residents, resident to resident interactions and staff to resident interactions. The Inspector reviewed records including residents' health care records, relevant licensee policies, investigation files, management correspondence to staff, an incident summary report and a record of a staff debriefing meeting.

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

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	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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, that the policy was in compliance with and was implemented in accordance with all applicable requirements under the Act.

The Long-Term Care Homes Act (LTCHA), S.O. 2007, c. 8, s. 20 (1) identifies that, 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.

Critical Incident System (CIS) reports were submitted for the witnessed abuse of resident #005 by resident #004 on dates in the fall and winter of 2017.

Inspector #625 reviewed the home's policy titled "Zero Tolerance of Abuse and/or Neglect – ADM 450", reviewed September 2015.

The Inspector noted the following entries which were not in compliance with the LTCHA, 2007, or Ontario Regulation 79/10:

(a) On page eight, the policy provided conflicting direction to staff with regards to the documentation of alleged abuse. The document advised staff to, "Document or write a brief, factual note…" and, "…writing the details of the suspected, alleged or witnessed incident of abuse or neglect as soon as possible." In contradiction, the same statement, within parenthesis, also cautioned staff not to include, "…allegations or opinion…"

The LTCHA, 2007, s. 20 (2) identifies that, at a minimum, the policy to promote zero

tolerance of abuse and neglect of residents, shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents.

The legislation identifies that the policy is to contain procedures for investigating and responding to alleged abuse and neglect. The legislation does not preclude the reporting of written allegations.

(b) On page eight, the policy reads that staff who are reporting a suspected, alleged or witnessed incident of resident abuse or neglect were to "Cooperate fully with those responsible for the investigation (e.g. home administrative staff, policy, MOHLTC Inspector). Note: It is the right of an employee who witnesses or suspects alleged abuse or neglect to be accompanied by a co-worker (or legal or union representative) during the investigatory meeting."

The LTCHA, 2007, s. 147 (1) (d) identifies that an Inspector conducting an inspection may question a person.

The legislation does not identify that the person being questioned by an Inspector can be accompanied by a co-worker, legal representative or union representative.

During an interview with the home's Administrator, they acknowledged that the home's zero tolerance of abuse and neglect policy identified that staff were permitted to have a co-worker, legal representative or union representative present during interviews with MOHLTC Inspectors. The Administrator stated that it may have been included as part of a union contract but that the policy would need to be updated with respect to the presence of others during interviews with MOHLTC Inspectors. [s. 8. (1) (a)]

2. The licensee has failed to ensure that, where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system, was complied with.

The LTCHA, 2007, s. 87 (1) (a) identifies that every licensee of a long-term care home is to ensure that there are emergency plans in place for the home that comply with the regulations, including measures for dealing with emergencies.

Ontario Regulation 79/10, s. 230 (2) requires every licensee of a long-term care home to ensure that the emergency plans for the home are in writing. Subsection (3) identifies

that the emergency plans must provide for dealing with fires.

A CIS report was submitted to the Director for a fire which occurred in the home on a date in the winter of 2017.

Inspector #625 reviewed the home's policy titled "Code Red – Fire – EMP 015", last reviewed January 2018, which identified that, upon hearing the fire alarm, those working in a particular location in the home were to shut off all equipment, turn off all lights and lock the door, and report to the Emergency Control Centre in the main lobby area.

Inspector #625 reviewed an undated document related to the fire in the winter of 2017, titled "Record of Staff Debriefing", provided to the Inspector by the home's Administrator. The document identified that the staff person had entered the home during the incident and opened a particular location, but should have been directed to wait in the main lobby as the incident was in process with three fire trucks at the main entrance and the alarm system engaged. The document identified that the person would receive an in-service on the protocol to follow during an emergency incident.

During an interview with the DOC, they indicated that the person and the home had an arrangement where the person worked out of the a particular location within the home.

The LTCHA, 2007, s. 2 (1) defines "staff", in relation to a long-term care home, to mean persons who work at the home,
(a) as employees of the licensee,
(b) pursuant to a contract or agreement with the licensee, or
(c) pursuant to a contract or agreement between the licensee and an employment agency or other third party.

During an interview with the Administrator, they confirmed that the "Record of Staff Debriefing" document was accurate with respect to the person opening the particular area during the incident, but that they should have been directed to wait in the main lobby. The Administrator acknowledged that the home's policy titled "Code Red – Fire – EMP 015" had not been followed, but should have been. [s. 8. (1) (b)]

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 that ensures that, where the Long-Term Care Homes Act (LTCHA), S.O. 2007, c.8, or Ontario Regulation (O. Reg.) 79/10 require the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system, (a) is in compliance with and is implemented in accordance with all applicable requirements under the Act; and (b) is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions.

A CIS report was submitted for the witnessed resident to resident abuse on a date in the fall of 2017, when resident #004 abused resident #005. Immediate actions taken to prevent recurrence listed in the report included "Currently looking at moving [resident #004] to another unit if a room swap is available". Long-term actions the home planned to correct the situation and prevent recurrence listed by the home included “Relocate [resident #004] to a different unit upon determining room swap availability”. A second CIS

report was submitted for resident to resident abuse 25 days after the first incident, on a date in the winter of 2017, when resident #004 again abused resident #005. Immediate actions taken to prevent recurrence listed in the report included moving resident #004 to another unit.

Inspector #625 reviewed the home's policy titled "Zero Tolerance of Abuse and/or Neglect – ADM 450", reviewed September 2015, which identified "All residents have the right to live in a home environment that treats them with dignity, respect and is free from any form of abuse or neglect at all times, and in all circumstances." The policy also indicated that the licensee was committed to zero tolerance of abuse or neglect of its residents.

A review of the health care records for residents #004 and #005 identified progress notes that were consistent with the information provided in the CIS reports regarding the abuse of resident #005 by resident #004, on dates in the fall and winter of 2017. A progress note dated seven days after the first incident of abuse, identified staff responded to resident #004 interacting adversely with resident #005, who had exhibited a responsive behaviour involving resident #004. The note identified that resident #004 "was very upset and unable to understand why this resident [kept exhibiting the responsive behaviour]". A note dated one day after the second incident in the winter of 2017, identified that resident #004 moved to another unit on that date.

During interviews with PSWs #105 and #106, they stated that resident #005 exhibited a particular responsive behaviour.

During an interview with PSW #107, they stated that resident #005 exhibited a particular responsive behaviour that involved resident #004.

During an interview with PSW #108, they stated that resident #005 exhibited a particular responsive behaviour and could not be redirected in one manner, but had to be redirected by staff in another manner. The PSW recalled that, during one of the incidents involving the two residents, resident #005 was exhibiting a particular responsive bevahiour and resident #004 was in a particular location prior to resident #004 abusing resident #005.

During an interview with RN #109, they stated that they recalled the incident in the fall of 2017, and believed that resident #005 had been in a specific area first and provoked resident #004, as resident #004 got very upset. The RN stated they thought resident

#004 had abused resident #005 after a particular interaction.

During an interview with the DOC, they stated that resident #005 exhibited a responsive behaviour involving resident #004 and, after the incident in the fall of 2017, the home had made plans to move resident #004. The DOC also stated that resident #004 was not moved to another unit until after the second incident of physical abuse involving resident #005 [26 days later]. [s. 54. (b)]

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 that ensures that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 77. Orientation for volunteers
Every licensee of a long-term care home shall develop and implement an orientation program for volunteers that includes information on,
(a) the Residents' Bill of Rights;
(b) the long-term care home's mission statement;
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
(d) the duty under section 24 to make mandatory reports;
(e) fire safety and universal infection control practices;
(f) any other areas provided for in the regulations; and
(g) the protections afforded by section 26. 2007, c. 8, s. 77; 2017, c. 25, Sched. 5, s. 19.

Findings/Faits saillants :

1. The licensee has failed to ensure that an orientation program for volunteers was developed and implemented that included information on fire safety.

A CIS report was submitted to the Director for a fire which occurred in the home on a date in the winter of 2017.

Inspector #625 reviewed an undated document related to the fire, titled Record of Staff Debriefing, provided to the Inspector by the home's Administrator. The document identified that volunteers engaged in a particular activity involving residents were "directed to stop [the activity] and proceed to M.P. room and wait for further instruction. Direction ignored by some."

During an interview with the Administrator, they stated that the home had not provided an orientation to its volunteers related to fire safety. [s. 77. (e)]

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 that ensures that an orientation program for volunteers is developed and implemented that includes information on fire safety, to be implemented voluntarily.

WN #4: 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, without in any way restricting the generality of the duty provided for in section 19, that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with.

CIS reports were submitted for the witnessed abuse of resident #005 by resident #004 on dates in the fall and winter of 2017.

Inspector #625 reviewed the home's policy titled "Zero Tolerance of Abuse and/or Neglect – ADM 450", last reviewed September 2015, which identified "If an incident of suspected, alleged or witnessed abuse or neglect meets the definition of abuse as outlined within this policy, a home must report the incident to the MOHLTC Director in the manner outlined in the MOHLTC Reporting Trees. (These decision trees are available at each nursing station)."

During an interview with RN #109, they stated that they had worked in the home for multiple years. The RN was not able to identify their role in immediately reporting abuse to the Director [LTC Inspections Branch] and stated that, if abuse had occurred during the night, they would wait until the morning and tell the home's DOC. The RN stated that they had never seen the decision trees, had not seen them on the units and was not sure that they were located on the units.

During an interview with the DOC, they identified that they had spoken to RN #109 about the decision trees, but had not been able to locate the decision trees on the second or third floors. [s. 20. (1)]

Issued on this 30th day of November, 2018

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

Original report signed by the inspector.