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
Aug 18, 2021	2021_879621_0008	008084-21	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

JULIE KUORIKOSKI (621)

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): August 9 - 11, 2021.

The follow intake was inspected upon during this Critical Incident System (CIS) Inspection:

- One intake related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Environmental Services Manager (ESM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a Housekeeping Aide and residents of the home.

The Inspector also completed daily tours of the resident care areas, observed the provision of care and services to residents, observed staff-to-resident interactions, reviewed relevant resident healthcare records, home's investigation records, employee training records, and applicable policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee has failed to ensure that a resident was protected from verbal abuse by a staff member.

Ontario Regulation (O. Reg.) 79/10, s. 2. (1), defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident".

A Critical Incident System (CIS) report was submitted to the Director, which identified that during care of a resident, one PSW witnessed another PSW become verbally abusive to the resident, in response to an escalation in responsive behaviours. The PSW who witnessed the incident also reported that the resident appeared afraid after how the PSW had responded to them. The outcome of the home's investigation identified that the PSW in question had verbally abused the resident.

During an interview with the PSW who was identified to have verbally abused the resident, they acknowledged the abuse.

Sources: Review of home's internal investigation notes, a CIS report, the resident's health care records; and interviews with PSW's, the DOC, and other relevant staff. [s. 19. (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 residents are protected from abuse by anyone and that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21. (1).

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).
3. Every designated cooling area, if there are any in the home. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

Temperature reports for the period of August 2 – 6, 2021, identified air temperatures measuring at or below 22 degrees Celsius for three out of four (75 per cent) of the rooms measured.

The ESM and Administrator confirmed that there were recorded temperatures below the minimum temperature requirements for three of the four rooms measured. The ESM also confirmed that, without proper monitoring and follow up, they were unable to ensure a comfortable environment was offered to all residents in the home.

Sources: The home's temperature reports for August 2021; and interviews with the ESM and Administrator. [s. 21. (1)]

2. The licensee has failed to ensure that temperatures were measured and documented

in writing, at a minimum, in at least two resident bedrooms in different parts of the home; one resident common area on every floor of the home, which may include a lounge, dining area or corridor; and every designated cooling area, if there were any in the home.

Temperature reports for the period of August 2 – 6, 2021, identified recorded temperatures only for a selection of resident bedrooms and one common area from one home area. The ESM reported that they were not aware of the legislative requirements for monitoring and recording air temperatures and confirmed that temperatures were not measured in all required areas in the home.

Sources: The home's temperature reports for August 2021; and interviews with the ESM and the Administrator. [s. 21. (2)]

3. The licensee has failed to ensure that temperatures required to be measured under subsection (2) were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Temperature reports, for the period of August 2 – 6, 2021, identified temperatures for a selection of resident bedrooms and one common area, from one home area only. The ESM confirmed that temperatures were not documented as required under subsection (2) at the required times in the home.

Sources: The home's temperature reports for August 2021; and interviews with the ESM and Administrator. [s. 21. (3)]

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 is maintained at a minimum temperature of 22 degrees Celsius; to ensure that temperatures are measured and documented in writing, at a minimum, in at least two resident bedrooms in different parts of the home and one resident common area on every floor of the home, which may include a lounge, dining area or corridor; and to ensure that temperatures required to be measured under subsection (2) are documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night, to be implemented voluntarily.

WN #3: 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 :

1. The licensee has failed to comply with s. 24 (1) 2. in that a person who had reasonable grounds to suspect abuse of a resident, failed to report the alleged abuse immediately to the Director in accordance with s. 24 (1) 2 of the LTCHA. Pursuant to s. 152 (2) the licensee was vicariously liable for staff members who failed to comply with subsection 24 (1).

A CIS report was submitted to the Director, which alleged verbal abuse of a resident by a PSW during care.

During an interview with the PSW who witnessed the incident, they reported that the incident had occurred during their shift the day prior, but did not report the incident to the RN on duty and the DOC until the next day.

The DOC, acknowledged that the incident was not reported to the Director immediately.

Sources: Review of home's internal investigation notes, a CIS report, the resident health care records; and interviews with a PSW, an RN, the DOC, and other relevant staff. [s. 24. (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 complaince with s. 24 (1) 2., in that a person who has reasonable grounds to suspect abuse of a resident, reports the alleged abuse immediately to the Director in accordance with s. 24 (1) 2 of the LTCHA. Pursuant to s. 152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1)., to be implemented voluntarily.

Issued on this 27th day of August, 2021

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

Original report signed by the inspector.