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 le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 20, 2015;	2015_289550_0003 (A2)	O-001613-15	Critical Incident System

Licensee/Titulaire de permis

BRUYERE CONTINUING CARE INC.
43 BRUYERE STREET OTTAWA ON K1N 5C8

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

RESIDENCE SAINT- LOUIS
879 CHEMIN PARC HIAWATHA OTTAWA ON K1C 2Z6

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

JOANNE HENRIE (550) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 11, 12 and 14 2015

The inspection also took place on March 5, 6, 9, 10 and 21, June 2, 3, 4, 15, 16 and 26 and July 3, 2015.

During the course of the inspection, the inspector(s) spoke with the Clinical Assistant Manager, several Registered Nurses, several Registered Practical Nurses, several Personal Support workers, a housekeeping aide and several residents. The inspector also reviewed a critical incident report, two resident's health records and the home's abuse policy.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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

7 WN(s)
0 VPC(s)
1 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. 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 :

1. The licensee failed to protect Resident #001 from sexual abuse by Resident #002.

Sexual abuse is defined by the LTCHA, 2007 as "any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or 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; ("mauvais traitement d'ordre sexuel")".

A Critical Incident report was submitted to the Director on a specific date in January 2015, at a sepcific time in the afternoon, reporting an incident of sexual abuse of Resident #001 by a person. At the time of the report, the Licensee was not aware that this person was Resident #002. The Critical Incident report indicated that the incident occurred on a specific date in January 2015. However, the progress notes indicated that the incident occurred on another specific date in January 2015, which was later confirmed by Resident #001.

In May 2014, Resident #001 was admitted to the home with multiple diagnoses. Resident #001 is alert and oriented, he/she is wheelchair bound and cannot mobilize the wheelchair on his/her own due to left side paralysis.

Resident #002 was admitted to the home in November 2014 with a known history of sexual behaviours. Inspector #550 reviewed Resident #002's progress notes from a specific the resident's admission day to the day of the incident in January 2015 and observed there were no documented incidents of inappropriate sexual behaviour during this period. Resident #2 was diagnosed with frontal lobe dementia and was receiving anti-psychotic medication to control aggressive behaviors. Resident #002's care plan dated a specific date in December 2014 indicated that this resident may have inappropriate sexual behavior and interventions were in place to mitigate this behaviour.

During an interview, Resident #001 told Inspector #550 that, on a specific date in

January 2015 at an undetermined time in the morning, he/she was in the chapel area, sitting in his/her wheelchair. Resident #002 was sitting in a chair close by; there was no other person present at that time. Resident #002 got up from his/her chair and went to see Resident #001. Resident #002 kissed Resident #001 on the cheek, then on the mouth, inappropriately touched a specific body part and undid the zipper of his/her pants. Resident #002 then asked Resident #001 if he/she wanted to touch his/her private parts. Resident #001 told Resident #002 to stop this and told Resident #002 to go sit down, and resident #002 did. Resident #001 did not report the incident that day because he/she felt ashamed Resident #002 did such a thing in a Chapel.

Resident #001 indicated he/she reported the incident on the next day to housekeeping Aide staff #S101 at breakfast time. Resident #001 told the housekeeping Aide that Resident #002 had kissed him/her on the cheek, and the mouth, inappropriately touched a specific body part and showed him/her his/her private parts. Resident #001 was holding Housekeeping Aide staff #S101's hand and pleading with her not to leave because the resident who abused him/her was sitting behind him/her and Resident #001 was afraid. Housekeeping Aide staff #S101 left Resident #001 in the dining room promising to come back but she never did.

Housekeeping Aide staff #S101 indicated to Inspector #550 during an interview that resident #001 had told her about the incident noted above, the morning on a specific date in 2015. Staff #S101 does not know why she did not report these allegations of sexual abuse to anyone. She indicated she received training on the home's abuse policy in the past year and that she should have known to report it immediately to her supervisor, further indicating she is usually vigilant about reporting such issues. Inspector #550 was unable to find any documentation indicating the Housekeeping Aide staff #S101 received the training on the home's abuse policy in the year 2014. Although Resident #001 indicated that the alleged abuser was in the dining room, Housekeeping Aide staff #S101 indicated that no attempts were made that morning to identify the resident in question.

That same day at a specific time in the evening, Resident #001 reported to PSW staff #S102 that he/she had been sexually abused by a resident. PSW staff #S102 immediately reported this incident to RN staff #S100 who was the nurse in charge of the unit at the time. According to an interview and in the progress notes of RN staff #S100, Resident #001 indicated to RN staff #S100 that the previous day in the morning he/she was sitting in the chapel area on the third floor and he/she was approached by another resident whom he/she later identified as Resident #002. Resident #002 leaned over Resident #001, kissed him/her on the right cheek, then on

the mouth, inappropriately touched a specific body part and then undid his/her own pants and asked Resident #001 if he/she wanted to touch his/her private parts. Resident #001 indicated to Resident #002 he/she was going to scream if he/she did not stop and instructed him/her to go sit down. Resident #002 went to sit in a chair in the chapel. Resident #001 did not know Resident #002's name but indicated to RN staff #S100 he/she saw him on a specific date in January 2015 sitting in the chapel area and again in the dining room at lunch and dinner. No attempt was made by RN #S100 to identify Resident #002.

RN staff #S100 reassured Resident #001 that a follow-up would be done. She documented the incident in Resident #001's progress notes and left a message on the voice mail of the Director of Care and the Assistant Clinical Manager. She did not call the Nursing Supervisor who was working off-site that evening. During an interview RN staff #S100 indicated to Inspector #550 that she considered this incident to be an incident of sexual abuse because Resident #001 did not consent to any of it. She indicated she did not report the incident to the to the Director, investigate, and notify the police because at the time, Resident #001 had not identified her abuser and it was impossible to do so around 6:00pm as Resident #001 was already in bed for the night as per his/her usual routine. RN staff #S100 further indicated to Inspector #550, that Resident #001 had informed the Housekeeping Aide that morning and no one had reported it internally therefore she did not feel the urgency to do so herself. RN staff #S100 documented the incident and left a message to the Director of Care and the Assistant Clinical Manager on their voice mail at work. She indicated to Inspector #550 she did receive the training on abuse in 2014.

Two (2) days after the incident, at some time in the morning upon her return to work, the Assistant Clinical Manager was made aware of this incident when she listened to a voice message left on her work voice mail by RN staff #S100. Upon receiving this information, the Assistant Clinical Manager immediately initiated an investigation into the allegation of sexual abuse. During an interview, the Assistant Clinical Manager indicated to Inspector #550 Housekeeping Aide staff #S101 should have immediately reported the incident to the nurse in charge of the unit when she was made aware by Resident #001. RN staff #S100 should have immediately reported the incident to the Nursing supervisor who was working off-site that evening as per their policy and that the Nursing Supervisor would have paged the Clinical on call who would have immediately notified the Director of the incident and guided the staff to inform police and start an investigation.

That same day at a specific time in the afternoon, a critical incident report was

submitted by the Assistant Clinical Manager to the Director reporting an incident of sexual abuse to Resident #001. The Assistant Clinical Manager also contacted the police and Resident #001's family to inform them of the incident of sexual abuse. She also initiated support to the resident by Spiritual Care Support and provided Resident #001 with a tambourine so he/she can call for assistance if he/she could not reach a call bell. Later that day, once the identity of Resident #002 was established around supper time, monitoring of Resident #002's whereabouts was done every 30 minutes to ensure other resident's safety.

In summary, on a specific date in January 2015, staff was made aware of an alleged incident of resident sexual abuse which had taken place the day before. This incident was not reported immediately to the Director as per section 24 (1) of the LTCH Act, 2007 (WN#4), nor was an investigation conducted that day as per section 23(1) of the LTCHA, 2007 (WN#3). The police was also not notified on this day in January 2015 as per section s.98 of Regulation 79/10 (WN#6).

In addition, the policy in place at the time of the inspection to promote zero tolerance of abuse and neglect of residents did not contain an explanation of the duty under section 24 to make mandatory reports (WN#2). And, finally as per section 76(4) of the LTCHA 2007, the licensee did not ensure that all staff receives retraining annually on the home's abuse policy (WN#5).

As a result of reviewing the severity and scope of the incident and the licensee's compliance history, the Inspector identified that a compliance order was warranted. There was a serious allegation of sexual abuse where Resident #001 was impacted by the incident. The scope level was identified as isolated. When reviewing the compliance history, the licensee has had previous non-compliance related to immediately reporting alleged abuse to the Director and immediately investigating incidents of abuse. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents shall:
(d) contain an explanation of the duty under section 24 of the Act to make mandatory reports.

Inspector #550 reviewed the home's abuse policy titled "Abuse, Patients, Residents, or Visitors", policy #CLIN CARE 32 with a revision date of 2013-10 which was their most recent policy as indicated by the Administrator/Clinical manager. The policy indicated:

4.1 The staff person who witness abuse, who believes that a patient or visitor has been or is at risk of being abused, or who is advised by a patient or visitor of abuse immediately reports the situation to the clinical manager/director of care/delegate, who in turn reports to the program director and the attending physician. (If the abuser is the person to whom one would normally report, report is to be made one level up.) Evening, nights, weekends, stat holidays: The nurse contacts the nursing supervisor (or the Clinical-on-Call if the nursing supervisor is not available), who in turn calls the Administrator-on-Call. The nursing supervisor or Clinical-on-Call advises the clinical manager/director of care on the next regular working day.

4.6 Long Term Care: The Director of Care (evening, nights, weekends, stat holidays: the nursing supervisor/Clinical-on-Call) must immediately report all alleged, suspected, or witnessed abuse to the Ministry of Health and Long Term Care duty inspector (phone: 1-855-819-0879; e-mail: ciattgeneral.moh@ontario.ca) as required under the Long Term Care Homes Act, along with a description of the steps taken to resolve the situation. (The nursing supervisor/Clinical-on-call notifies the Director of Care by email of any such report that she has made.)

Inspector #550 determined that the policy did not contain all the requirements under s. 24 of the LTCH Act. It did not identify that if 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:
• Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident,
• Unlawful conduct that resulted in harm or a risk of harm to a resident,
• Misuse or misappropriation of a resident's money and
• Misuse or misappropriation of funding provided to a licensee under the LTCH Act or the Local System Integration Act, 2006.

The policy did not indicate the after- hours MOHLTC contact information. [s. 20. (2)]

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated:
(i) Abuse of a resident by anyone.

During an interview RN staff #S100 indicated to Inspector #550 that she considered the incident of a specific date in January 2015 (see WN#1) to be an incident of sexual abuse because Resident #001 did not consent to any of it. She indicated she did not report the incident to the to the Director, investigate, and notify the police because at the time, Resident #001 had not identified the abuser and it was impossible to do so around 6:00pm as Resident #001 was already in bed for the night as per his/her usual routine.

During an interview, the Assistant Clinical Manager indicated to Inspector #550 RN staff #S100 should have immediately reported the incident to the Nursing supervisor who was working off-site that evening as per their policy and that the Nursing Supervisor would have paged the Clinical on call who would have immediately notified the Director of the incident and guided the staff to inform police and start an investigation. [s. 23. (1) (a)]

WN #4: The Licensee has failed to comply with LTCHA, 2007, 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. During an interview, Resident #001 told Inspector #550 that, on a specific date in January 2015 at an undetermined time in the morning, he/he was in the chapel area, sitting in his/her wheelchair. Resident #002 was sitting in a chair close by; there was no other person present at that time. Resident #002 got up from his/her chair and went to see Resident #001. Resident #002 kissed Resident #001 on the cheek, then on the mouth, touched a specific body part and then undid the zipper of his/her pants. Resident #002 asked Resident #001 if he/she wanted to touch his/her private parts. Resident #001 told Resident #002 to stop this and to go sit down, and Resident #002 did. Resident #001 did not report the incident that day because he/she felt ashamed Resident #002 did such a thing in a Chapel.

Resident #001 indicated he/she reported the incident the next day to Housekeeping Aide staff #S101 at breakfast time.

Housekeeping Aide staff #S101 indicated to Inspector #550 during an interview that Resident #001 had told her about the incident noted above the morning of a specific date in January 2015. Staff #S101 does not know why she did not report these allegations of sexual abuse to anyone. She indicated she received training on the home's abuse policy in the past year and that she should have known to report it immediately to her supervisor, further indicating she is usually vigilant about reporting such issues.

That same day at a specific time in the evening, Resident #001 reported to PSW staff #S102 that he/she had been sexually abused by a resident. PSW staff #S102 immediately reported this incident to RN staff #S100 who was the nurse in charge of the unit at the time. During an interview, RN staff #S100 indicated to Inspector #550 she documented the incident in Resident #001's progress notes and left a message on the voice mail of the Director of Care and the Assistant Clinical Manager. She did not call the Nursing Supervisor who was working off-site that evening. RN staff #S100 indicated to Inspector #550 that she considered this incident to be an incident of sexual abuse because Resident #001 did not consent to any of it. She indicated she did not report the incident to the to the Director because at the time, Resident #001 had not identified the abuser and it was impossible to do so around 6:00pm as Resident #001 was already in bed for the night as per his/her usual routine. RN staff #S100 further indicated to Inspector #550 Resident #001 had informed the Housekeeping Aide that morning and no one had reported it internally therefore she did not feel the urgency to do so herself. RN staff #S100 documented the incident and left a message to the Director of Care and the Assistant Clinical Manager on their voice mail at work.

Two (2) days after the incident at some time in the morning upon her return to work, the Assistant Clinical Manager was made aware of this incident when she listened to a voice message left on her work voice mail by RN staff #S100. Upon receiving this information, the Assistant Clinical Manager immediately initiated an investigation into the allegation of sexual abuse. During an interview, the Assistant Clinical Manager indicated to Inspector #550 Housekeeping Aide staff #S101 should have immediately reported the incident to the nurse in charge of the unit when she was made aware by Resident #001. RN staff #S100 should have immediately reported the incident to the Nursing supervisor who was working off-site that evening as per their policy and that the Nursing Supervisor would have paged the Clinical on call who would have immediately notified the Director of the incident and guided the staff to inform police and start an investigation. [s. 24. (1)]

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training
Specifically failed to comply with the following:

s. 76. (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section. 2007, c. 8, s. 76. (1).

Findings/Faits saillants :

1. According to the Act section 76 (1), every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section which includes subsection 76 (3).
3. The long term care home's policy to promote zero tolerance of abuse and neglect of residents. According to the Act subsection 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. In accordance with the regulation section 219 (1), the retraining intervals for the purposes of subsection 76 (4) of the Act are annual intervals.

Inspector #550 reviewed the home's training education that was made available to all staff in 2014 on the home's abuse policy and observed that 245/325 employees did not receive retraining by attending a training session or e-learning module.

The Assistant Clinical Manager indicated to Inspector #550 during an interview she is aware the home is having issues with education to staff and that their attendance is not 100% for the education on their abuse policy. [s. 76. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

During an interview RN staff #S100 indicated to Inspector #550 that she considered the incident of a specific date in January 2015 (see WN#1) to be an incident of sexual abuse because Resident #001 did not consent to any of it. She indicated she did not notify the police that evening because at the time, Resident #001 had not identified the abuser and it was impossible to do so around 6:00pm as Resident #001 was already in bed for the night as per his/her usual routine.

During an interview, the Assistant Clinical Manager indicated to Inspector #550 RN staff #S100 should have immediately reported the incident to the Nursing supervisor who was working off-site that evening as per their policy and that the Nursing Supervisor would have paged the Clinical on call who would have immediately notified the Director of the incident and guided the staff to inform police.

The police was notified of the incident on a specific date in January 2015. [s. 98.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Resident #002 has a prescription for a specific anti psychotic medication to be taken by mouth if required (in addition to the regular dose) and a specific benzodiapine medication to be taken by mouth if required, may repeat x1 for agitation (max 2 tabs per day). Inspector #550 reviewed Resident #002's medication administration records for the months of November, December 2014, January and February 2015. It was observed the resident received the following medication for agitation on the following dates:

a specific anti psychotic:
11 specific dates in December 2014,
2 specific dates in January 2015 and,
3 specific dates in February 2015.

a specific Benzodiazepine:
1 specific date in January 2015.

There is documented evidence to indicate that the effect of these drugs was being monitored in order to address the agitation although there was no documentation on the resident's response/outcome to these medication.

The Assistant Clinical Manager indicated to Inspector #550 during an interview it is the home's expectation that registered staff document the effectiveness of the administered medication on the Medication Administration Record sheet but it was not done. [s. 134. (a)]

Issued on this 20 day of November 2015 (A2)

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

Original report signed by the inspector.