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
May 21, 2020	2020_824765_0005	000064-20	Critical Incident System

Licensee/Titulaire de permis

Bingham Memorial Hospital
507 8th Avenue PO Box 70 Matheson ON P0K 1N0

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

Rosedale Centre
507 - 8th Avenue P.O. Box 70 Matheson ON P0K 1N0

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

HILARY ROCK (765), MICHELLE BERARDI (679)

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 2 - 4, 2020. Additional offsite activities were completed on March 9 - 11, 2020.

One intake was completed in this Critical Incident System Inspection which was related to alleged resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the previous Director of Care (DOC) #100, Director of Care (DOC) #101, Recreation Therapist Behavioural Supports Ontario (BSO), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The inspector(s) also observed resident care areas, the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, internal investigation documents, policies and procedures.

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

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A Critical Incident System (CIS) report was submitted to the Director related to resident #001 to resident #002 alleged abuse on a specified date.

During an interview with Inspector #765, Director of Care (DOC) #100 indicated that a specified intervention for resident #001 was initiated after the incident. However, DOC #100 indicated they did not update the care plan.

Inspector #765 reviewed resident #001’s care plan and could not identify that the specified intervention was ever added.

During an interview with Inspector #765, Personal Support Worker (PSW) #105 stated that if a resident had the specified intervention that it should be documented in their care plan on Point Click Care (PCC).

During separate interviews with Inspector #765; PSW #102 and Registered Practical Nurse (RPN) #104 stated that the residents’ care plans were utilized to identify the care needs of the resident.

In an interview with Inspector #765, DOC #101 stated that staff had been completing the specified intervention for resident #001. DOC #101 indicated that the staff were consistent and that they knew about resident #001’s behaviours. DOC #101 stated that it should have been identified in the care plan. [s. 6. (1) (a)]

2. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A CIS report was submitted to the Director related to resident #001 to resident #002 alleged abuse on a specified date.

Inspector #765 reviewed resident #001's current care plan which indicated that there was no specified type of transfer assistance. In contrast, resident #001's dashboard advised staff to provide a different type of transfer assistance than the one RPN #104 indicated.

In an interview with Inspector #765 and Inspector #679, DOC #101 indicated that resident #001 had a change in status and required a specified transfer assistance. DOC #101 stated that the resident's dashboard described the need for a different specified transfer assistance. DOC #101 confirmed that resident #001's care plan which indicated that resident #001 did not need a specified transfer assistance, did not reflect the same care needs as the dashboard. [s. 6. (1) (c)]

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provided direct care to the resident, to be implemented voluntarily.

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

A CIS report was submitted to the Director related to resident #001 to resident #002 alleged abuse on a specified date.

Inspector #765 reviewed a submitted CIS report that indicated resident #001 was spoken to regarding a specified topic. The CIS report indicated that resident #001 was made aware that a specified action would occur if no changes were made.

Inspector #765 reviewed the licensee's policy "Zero Tolerance of Abuse and Neglect," which provided a definition of abuse that included threatening or intimidating remarks and communication. The policy included that they were "committed to a zero tolerance of abuse or neglect to its residents" and that they "shall uphold the right of residents in their homes to be treated with dignity and to live free from abuse and neglect."

Inspector #765 interviewed resident #001 who indicated that they remembered the conversation with DOC #100 and would prefer the specified action not occur.

During an interview with Inspector #765, DOC #100 indicated that some aspects of what they said to resident #001 could have caused the resident to feel threatened and it was quite possible that resident #001 did see it as a threat. [s. 20. (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 the written policy to promote zero tolerance of abuse and neglect of residents is complied with, 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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that when a person had reasonable grounds to suspect that any of the following had occurred, they immediately reported the suspicion and the information upon which it was based to the Director: Abuse of a resident by anyone that resulted in harm or a risk of harm to the resident.

A CIS report was submitted to the Director related to resident #001 to resident #002 alleged abuse on a specified date.

a) Inspector #765 reviewed a CIS report which indicated that an incident occurred on a specified date; however, it was not reported to the Director until the day after.

Inspector #765 reviewed the licensee's policy "Duty to Report," which indicated that "Any staff or board member who is aware of or suspects any of the following must report it as soon as possible in accordance with the reporting procedures in this policy: Abuse of a resident by anyone." The policy further indicated "Information to be reported immediately to the Ministry – Abuse of a resident by anyone."

During an interview with Inspector #765, RPN #104 stated that in an event of alleged abuse they tried to maintain safety for all residents, report anything to the DOC, started an electronic internal investigation document, and then reported it to "the Ministry" if it was a critical incident.

During an interview with Inspector #765 and Inspector #679, DOC #101 indicated that the process for reporting abuse would include submitting a CIS and to call the action line if it was immediate and then follow up in 10 days.

During an interview with Inspector #765 and Inspector #679, DOC #100 indicated that they were notified and followed up on the potential abuse incident on a specified date, and that it was a holiday. DOC #100 said they should have called that after-hours line on the specified date.

b) Inspector #765 reviewed resident #001's progress notes in PCC which indicated a specified number of entries from a specified month that resident #001 was abusive to resident #002.

Inspector #765 reviewed resident #002's progress notes in PCC which indicated a specified number of entries from a specified month that resident #002 expressed to staff that they had become afraid of resident #001.

Inspector #765 reviewed the licensee's policy "Zero Tolerance of Abuse and Neglect," which indicated that "Abuse of a resident means: Any threatening, insulting, intimidating or humiliating gestures, actions, behavior or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behavior or remarks understands and appreciates their consequences."

In an interview with DOC #100, they indicated to Inspector #765 that none of the other incidents between resident #001 and resident #002 were reported to "the Ministry" and that was why they thought it was time to report to "the Ministry" on a specified date.

During an interview with Inspector #765 and Inspector #679, DOC #101 indicated that the incident from a specified previous month, was not reported to "the Ministry" and should have been. [s. 24. (1) 2.]

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 when a person had reasonable grounds to suspect that any of the following had occurred, they immediately reported the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone that results in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
6. Psychological well-being. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident mood and behaviour patterns, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

A CIS report was submitted to the Director related to resident #001 to resident #002 alleged abuse on a specified date.

Inspector #765 reviewed resident #001’s progress notes on PCC and discovered incidents of specified behaviours documented a specified amount of times in a specified period.

Inspector #679 identified a specified document which indicated that resident #001 exhibited specified behaviours.

Inspector #765 reviewed a specified document which identified resident #001 exhibited specified behaviours directed toward a specified resident.

Inspector #765 reviewed resident #001's care plan and did not identify any indication the resident had the potential to exhibit specified behaviours or interventions regarding their other specified behaviour.

In separate interviews with Inspector #765, Recreation Therapist Behavioural Supports Ontario (BSO) #103 and RPN #104 indicated that resident #001 had and had shown some specified behaviours. BSO #103 mentioned that they could not find anything related to the specified behaviours in their care plan.

In an interview with Inspector #765, DOC #101 confirmed that resident #001's specified behaviours should have been in their care plan. [s. 26. (3) 5.]

2. The licensee failed to ensure that a plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Psychological well-being.

A CIS report was submitted to the Director related to resident #001 to resident #002 alleged abuse on a specified date.

Inspector #765 reviewed resident #001's progress notes in PCC and on a specified date, a BSO progress note identified a specified concern.

Inspector #765 reviewed resident #001's care plan and did not identify any indication that they exhibited a specified concern.

In separate interviews with Inspector #765 and Inspector #679, BSO #103 and RPN #104 indicated that resident #001 stated they had a specified concern during a specified meeting. BSO #103 mentioned that they made some changes; however, they could not find anything in their care plan regarding a specified concern. BSO #103 and RPN #104 confirmed that it should have been in the care plan.

In an interview with Inspector #765, DOC #101 stated that if resident #001 had a specified concern that it should have been identified in their care plan. [s. 26. (3) 6.]

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 plan of care is based on, at a minimum, interdisciplinary assessment of the following with respect to the resident mood and behaviour patterns, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day; and to ensure that a plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident psychological well-being, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure the responsive behaviour program was evaluated annually.

Inspector #679 reviewed the policy titled “Responsive Behaviour Program” which indicated a specified last reviewed date.

Inspector #679 requested documentation related to the review of the responsive behaviour program for a specified year.

In an interview with the DOC, Inspector #679 questioned if the responsive behaviour program was evaluated annually and updated in accordance with evidence-based practices or prevailing practices. The DOC stated "not that they could remember." The DOC further indicated that they could not find any documentation to indicate the program was reviewed and identified that the review date listed on the policy would indicate the last time the policy was reviewed. [s. 53. (3) (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 to ensure the responsive behaviour program is evaluated annually, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 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. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff received training annually related to the home's policy to promote zero tolerance of abuse and neglect of residents.

A CIS report was submitted to the Director related to resident #001 to resident #002 alleged abuse on a specified date.

Inspector #679 requested a copy of the home's abuse and neglect education records for a specified year. Together, Inspector#679 and the DOC reviewed a spreadsheet which indicated that the PSWs and Registered staff were provided with abuse education in the specified year. The Inspector asked for clarification regarding other staff members of the home including whether dietary and housekeeping staff had received education on abuse and neglect for the specified year. The DOC indicated the staff who worked in support services were not assigned to complete the abuse and neglect education course in the specified year. [s. 76. (4)]

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 all staff receive training annually related to the home's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #7: 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 SDM and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that: resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

A CIS report was submitted to the Director related to resident #001 to resident #002 alleged abuse on a specified date.

Inspector #765 and Inspector #679 reviewed resident #002’s progress notes and the home's electronic incident report system and could not identify any indication that resident #002’s Substitute Decision Maker (SDM) was notified of the incident of abuse.

Inspector #765 and Inspector #679 also reviewed resident #001 and resident #002’s progress notes and the home's electronic incident report system regarding the incidents from October 2019, and could not identify any indication that either of the resident’s SDMs were notified of the incident of abuse. See WN #3-B for further details.

A review of the policy titled “Zero Tolerance of Abuse and Neglect,” identified that staff were to immediately notify the SDM or person requested by the resident of the incident if the resident if the resident was harmed, and within 12 hours for all other situations of alleged or witnessed abuse or neglect.

In an interview with Inspector #765 and Inspector #679, RPN #104 indicated that they were to notify both resident's SDMs regarding any altercation or abuse.

In an interview with Inspector #679, the DOC #101 stated that they would notify resident's SDM about incidents of abuse and would document the conversation in PCC under POA communication. DOC #101 indicated that the time frame of notifying the SDMs was dependant on the severity of the offense but they would say by the morning they would contact them.

In an interview with Inspector #765 and Inspector #679, DOC #100 confirmed that they did not contact resident #002's family regarding the incident of abuse. [s. 97. (1) (a)]

2. The licensee has failed to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident was notified within 12 hours upon the licensee being aware of any alleged suspected or witnessed incident of abuse or neglect of the resident.

Inspector #679 reviewed resident #003's electronic progress notes from PCC and identified an incident between resident #003 and resident #004. Inspector #679 did not identify any documentation to support that resident #003's SDM was made aware of the incident.

A review of resident #004's electronic progress notes indicated the incident with specified details. Inspector #679 did not identify any documentation to support that resident #004's SDM was made aware of the incident.

Inspector #679 reviewed the home's internal reporting record and identified a safety/security event report which detailed the incident between residents #003 and #004. The Inspector did not identify any documentation to indicate that the resident's SDMs were notified of the incident.

In an interview with Inspector #679, DOC #101 identified that a resident's SDM would be notified of incidents of abuse via telephone, and that this would be documented in PCC under "POA communication". When asked if there was a time frame in which SDMs were notified, the DOC indicated it would depend on the severity of the offense, and that they would say "definitely by the morning". The DOC reviewed the electronic progress notes regarding the incident and stated that it did not indicate in the progress notes that the SDMs were made aware of the incident. [s. 97. (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 to ensure that the resident's SDM and any other person specified by the resident are immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that: resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident's health or well-being, to be implemented voluntarily.

Issued on this 27th day of May, 2020

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

Original report signed by the inspector.