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
Dec 7, 2018	2018_683126_0019	013018-17, 014489-17, 017317-17, 022322-17, 025332-17, 025375-17, 025429-17, 026584-17, 029464-17, 007357-18, 010419-18	Critical Incident System

Licensee/Titulaire de permis

The Governing Council of the Salvation Army in Canada
2 Overlea Blvd TORONTO ON M4H 1P4

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

The Salvation Army Ottawa Grace Manor
1156 Wellington Street OTTAWA ON K1Y 2Z3

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

LINDA HARKINS (126), ANANDRAJ NATARAJAN (573)

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): September 11, 13, 14, 17, 18, 19, 20, 21, 24, 25, 26, October 1, 2, 3, 2018

During this inspection the following Critical Incident (CIS) Logs were inspected:
Log: #013018-17 (CIS #2873-000014-17) related to allegation of abuse (reported as an incident that cause an injury ...) Area of non-compliance issued under complaint inspection #2018_730593_0013.
Log #025375-17 (CIS #2873-000032-17) related to allegation of abuse. Area of non-compliance issued under complaint inspection #2018_730593_0013.
Log #007357-18 (CIS #2873-000012-18) related to allegation of physical abuse resident to resident. Area of non-compliance issued under complaint inspection #2018_730593_0013.
Log #014489-17 (CIS # 2873-000015-17) related to incident that causes an injury to a resident for which the resident is taken to hospital and that resulted in a significant change in the resident's health status.
Log #017317-17 (CIS # 2873-000016-17) related to incident that causes an injury to a resident for which the resident is taken to hospital and that resulted in a significant change in the resident's health status.
Log #022322-17 (CIS # 2873-000025-17) related to incident that causes an injury to a resident for which the resident is taken to hospital and that resulted in a significant change in the resident's health status.
Log #025332-17 (CIS # 2873-000030-17) related to incident that causes an injury to a resident for which the resident is taken to hospital and that resulted in a significant change in the resident's health status.
Log #025429-17 (CIS # 2873-000031-17) related to incident that causes an injury to a resident for which the resident is taken to hospital and that resulted in a significant change in the resident's health status.
Log #026584-17 (CIS # 2873-000034-17) related to incident that causes an injury to a resident for which the resident is taken to hospital and that resulted in a significant change in the resident's health status.
Log #029464-17 (CIS # 2873-000035-17) related to incident that causes an injury to a resident for which the resident is taken to hospital and that resulted in a significant change in the resident's health status.
Log #010419-18 (CIS # 2873-000015-18) related to incident that causes an injury to a resident for which the resident is taken to hospital and that resulted in a significant change in the resident's health status. Area of non-compliance issued under complaint inspection # 2018_730593_0013.

During the course of the inspection, the inspector(s) spoke with The Executive Director (ED), the Director of Care (DOC) , the Assistant Director of Care (ADOC), the Director of Employee Relations, the Scheduler, Registered Nurses (RN),

Registered Practical Nurses (RPN), Personal Support Workers (PSW) and several residents.

During the course of the inspection, the inspector reviewed Critical Incident (CI) reports, resident health care records, licensee's relevant policies and procedures. In addition the inspector observed the provision of care and services to residents and observed staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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. 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. Related to log # 025375-17
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.

On a specific day, resident #003 was heard yelling and when Registered Practical Nurse (RPN) #107 looked up, they observed resident #002 punching resident #003 in the face. Resident #003 was crying and was upset for a short time, some redness was observed to the left jaw. Following the incident, Registered Nurse (RN) #108 immediately contacted the MOHLTC's Director to notify of the abuse, resident to resident and a Critical Incident Form was submitted.

A discussion was held with Director Of Care (DOC) #100 who indicated that several investigations have been conducted regarding abuse in the home. At the time of the interview, the investigation notes were not available. Both residents' health care records were reviewed and no documentation was found related to an investigation conducted regarding the incident. During the course of this inspection the investigation notes were not provided to Inspector #126.

As such, the investigation related to this incident was not immediately investigated. [s. 23. (1) (a)]

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 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following description of the incident including the type of incident.

On a specific day an incident of suspicious abuse between resident #001 and resident # 002, was immediately reported to the Director. It was noted that this incident was submitted via the Critical Incident System as an "incident that causes an injury to a resident for which the resident is taken to the hospital and which results in a significant change in the resident's health status".

On a specific day an incident of physical abuse between resident #001 to resident # 003 was immediately reported to the Director. It was noted that this incident was submitted via the Critical Incident System as an "incident that causes an injury to a resident for which the resident is taken to the hospital and which results in a significant change in the resident's health status".

As such, the licensee failed to report these incidents as per the type of incident which were abuse, not a transfer to hospital. [s. 104. (1) 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 report to the Director included the following description of the incident including the type of incident,, to be implemented voluntarily.

WN #3: 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. Related to log # 025375-17
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 suspected may constitute a criminal offence.

On a specific day, resident #003 was heard yelling and when Registered Practical Nurse (RPN) #107 looked up, they observed resident #001 punching resident #003 in the face. Resident #003 was crying and was upset for a short time, some redness was observed to the left jaw. Following the incident, Registered Nurse (RN) #108 immediately contacted the MOHLTC's Director to notify of the abuse, resident to resident and a Critical Incident Form was submitted.

In reviewing the documentation related to the incident of abuse between resident #001 and resident #003, it was noted that the police force were not contacted.

In reviewing resident #001 health care record, it was noted that on a specific day, resident #001 pushed resident #005 to the ground, unprovoked. Resident #005 was walking by resident #001's bedroom to go the lounge. Resident #001 came out of the room and resident #005 said hello to resident #001, resident #001 pushed resident #005 with both hands on their chest and resident #005 fell to the ground, hit their head and was complaining of back pain. There was no documentation indicating that the police was notified.

A discussion was held with Assistant Director Of Care (ADOC) # 101, who indicated that if it was not documented in the documentation provided to Inspector # 126, then it was not done.

As such, the police force was not contacted following this incident of resident to resident physical abuse. [s. 98.]

Issued on this 17th day of December, 2018

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

Original report signed by the inspector.