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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Apr 11, 2019	2019_665551_0005	006019-18, 027204-18, 028316-18, 030228-18, 031185-18, 032452-18, 033059-18, 033300-18, 033525-18	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

MEGAN MACPHAIL (551)

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 26, 27, 28 and 29 and April 1, 2, 3, 4 and 5, 2019.

The following logs were inspected:

006019-18 / CIS 2873-000006-18 related to an allegation of resident to resident abuse.
027204-18 / CIS 2873-000023-18 related to an allegation of improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
028316-18 / CIS 2873-000025-18 related to an allegation of resident to resident abuse.
030228-18 / CIS 2873-000028-18 related to an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.
031185-18 / CIS 2873-000030-18 related to an allegation of staff to resident abuse.
032452-18 / CIS 2873-000034-18 related to an allegation of resident to resident abuse.
033059-18 / CIS 2873-000020-18 related to an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.
033300-18 / CIS 2873-000036-18 related to an allegation of improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
033525-18 / CIS 2873-000039-18 related to a missing or unaccounted for controlled substance.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), including a Behaviour Support Ontario (BSO) PSW, Registered Nursing Staff, the Staff Scheduler, the Acting Director of Resident Care (DRC) and the Executive Director.

During the course of the inspection, the inspector(s) reviewed health care records, the licensee's investigation files (for selected Critical Incidents) and observed staff and resident interactions.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **3 WN(s)**
- **1 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).

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that appropriate action was taken in response to an allegation of staff to resident abuse.

Critical Incident System (CIS) #2873-000030-18 was submitted to the Director under LTCHA, 2007, s. 24 to report an incident of suspected staff to resident abuse. The after-hours line was contacted on a specified date, and the CIS was submitted the following day.

According to the CIS, resident #005 sustained a specific injury. The CIS stated that the resident had been resistive while two PSWs were attempting to do the resident's morning care.

Resident #005's health care record was reviewed and the home's investigation file was obtained from the Acting Director of Resident Care (DRC). The file consisted of one staff interview (PSW #116), a Risk Management Incident Report and a Weekly Wound

Assessment for New Skin Issues, both completed on the day that the injury was discovered, a print out of progress notes and pictures of PSW #116's arms and cheek.

The licensee did not take appropriate action following an allegation of staff to resident abuse as on a specified date:

- an injury to a specific body part was discovered.

- PSWs #111 and #116, who had been assigned to perform the resident's care on the day that the injury was sustained, continued to be assigned to the same unit as the resident with no restriction on providing care to resident #005.

- only 1 staff member, PSW #116, was interviewed as part of the licensee's investigation.

- photos taken of the resident's injury on the day that it was discovered by RN #118 were not shared until April 4, 2019.

- the police were not notified when the resident sustained an injury, and abuse was suspected. [s. 23. (1) (b)]

2. The licensee has failed to ensure that the results of an investigation into an allegation of improper or incompetent care of a resident was reported to the Director.

Critical Incident System (CIS) #2873-000036-18 was submitted to the Director under LTCHA, 2007, s. 24 to report an incident of suspected improper or incompetent care of resident #011. The after-hours line was contacted on a specified date, and the CIS was submitted the following day.

According to a review of resident #011's health care record, an injury to a specific body part was discovered on a specified date.

The CIS was not amended to report the results of the licensee's investigation to the Director. [s. 23. (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 appropriate action is taken in response to all allegations of staff to resident abuse; and to ensure that results of investigations as required under LTCHA, s. 23 are reported to the Director, to be implemented voluntarily.

WN #2: 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 an incident of abuse of resident #003 that the licensee suspected may constitute a criminal offence.

Critical Incident System (CIS) #2873-000006-18 was submitted to the Director under LTCHA, 2007, s. 24 to report an incident of resident to resident abuse. The after-hours line was contacted on a specified date, and the CIS was submitted the following day.

According to the CIS, resident #002 was physically abusive to resident #003.

According to the Acting DRC, the incident may have constituted a criminal offence, and police should have been called. [s. 98.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
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. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included a description of the incident, including the events leading up to the incident.

On December 24, 2018, CIS #2873-000039-18 was submitted to the Director under O. Reg. 79/10, s. 107 (3) (4) to report a missing or unaccounted for controlled substance.

The CIS stated that the incident occurred on December 21, 2018 at 0700 hours on a specific unit, and stated "Narcotic count wrong". The type of narcotic was not specified, and no other tangible details other than that the count was wrong were provided.

Six staff members were listed as responding to the critical incident, but it did not specify who was working where on what shift. A staff schedule was obtained for December 21, 2018, and it indicated that three RPNs who were listed as responding to the incident had not worked on December 21, 2018 or the night shift of December 20/21, 2018.

No tangible information was provided to describe the incident or the events leading up to the incident. [s. 107. (4) 1.]

Issued on this 11th day of April, 2019

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

Original report signed by the inspector.