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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Jan 22, 2014	2014_295556_0001	000003-14	Critical Incident System

Licensee/Titulaire de permis

peopleCare Not-For-Profit Inc
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

WENDY PATTERSON (556)

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): January 16 & 17, 2014.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), RAI Coordinator, Employee Benefits Administrator (EBM), one Dietary Aide, one Volunteer, three Registered Practical Nurses (RPN), one Personal Support Worker (PSW), and one Registered Nurse (RN).

During the course of the inspection, the inspector(s) reviewed resident #001, #002, and #003's health care records, observed staff/resident interaction, toured two resident care areas, reviewed the policy #A11 Zero Tolerance of Abuse and Neglect revised September 2011, and policy #F9 Responsive Behaviours Program revised December 2013, reviewed the homes internal investigation documentation for the incident of a specified date, and reviewed the specific critical incident.

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

Findings of Non-Compliance were found during this inspection.

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.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. A review of the Critical Incident System (CIS) Report submitted to the MOHLTC on a specified date indicates that on a specified date staff member S109 was observed by staff members S104, S111, and S110 forcing resident #001 to sit down in the dining room chair.

Staff member S104 who witnessed the incident stated that staff member S109 forced resident #001 abruptly from a standing position down into a chair during the noon meal, told resident #001 to get out of the dining room, and then blocked resident #001 from returning to the dining room.

A review of the homes investigation regarding the incident of alleged staff to resident abuse indicates that staff member S104, who witnessed the alleged abuse, reported it to the RPN at the time of the incident. The RPN reported the alleged abuse to the RN who emailed the ED at 2:54pm on the date of the incident. The ED acknowledged receipt of the email approximately two hours later.

The homes internal investigation notes indicate that an internal investigation into the incident was initiated four days after the incident. In an interview, the ED stated that the investigation was initiated on a specified date and the home had concluded that staff to resident abuse had occurred and resulted in disciplinary action to staff member S109.

As such an immediate investigation into alleged, suspected or witnessed abuse of a resident was not immediately investigated. [s. 23. (1) (a)]

WN #2: 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. A review of a Critical Incident System (CIS) Report submitted to the MOHLTC on a specified date indicates that an incident of alleged staff to resident abuse of resident #001 by staff member S109 took place on a specified date when staff member S109 was observed by staff members S104, S111, and S110 forcing resident #001 to sit down in the dining room chair.

A review of the homes investigation regarding the incident of alleged staff to resident abuse indicates that staff member S104, who witnessed the alleged abuse, reported it to the RPN at the time of the incident. The RPN reported the alleged abuse to the RN who emailed the ED at 2:54pm on the day of the incident. The ED acknowledged receipt of the email approximately two hours later.

During the course of the inspection, Inspector #556 reviewed the internal investigation documentation for the staff to resident abuse and noted that the documentation refers to staff member S109 pushing resident #004 towards the dining room, waving a hand in the resident's face, and speaking inappropriately to resident #004 resulting in Resident #004 crying. In addition staff member S109 was also observed pushing resident #001 abruptly from a standing position down into a chair on two occasions during the noon meal, telling Resident #001 to get out of the dining room, and blocking resident #001 from returning to the dining room.

In an interview with the ED, and the EBA, the EBA confirmed that there was a second resident involved in the incident who was also abused by staff member S109.

During an interview Staff member S104 stated that he/she was present at the time of the incident and he/she witnessed staff member S109 walking with resident #004 towards the dining room table when the resident stopped and staff member S109 grabbed Resident #104 by the waistband of his/her pants and forced him/her forward to a chair and pushed him/her down into it saying "sit down" in a loud voice. Staff member S104 stated that Resident #004 was visibly upset, and was crying and sobbing. At that time Resident #001 who had been sitting at the table got up and walked away and staff member S109 grabbed his/her walker and pulled Resident #001 by the walker back to his/her chair and forced him/her down into the chair and loudly said "don't move". When the resident got up again, staff member S109 took him/her out of the dining room and told him/her in a loud voice not to come back in, that he/she would not allow him/her back in the dining room.

In an interview with the DOC and the ED the DOC stated that the MOHLTC was initially notified of the alleged staff to resident abuse of Resident #001 four days after the incident. The Executive Director stated that he was not aware of a report being submitted to the MOHLTC related to the alleged abuse of resident #004.

As such, the licensee did not immediately report the alleged abuse of resident #001 and resident #004 to the Director. [s. 24. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. A Critical Incident System (CIS) Report was submitted to the MOHLT on a specified date reporting an incident of alleged staff to resident abuse by staff member S109 to Resident #001.

During the course of the inspection into the critical incident, Inspector #556 reviewed the medical record of Resident #001 which indicated that Resident #001 was admitted to the home on a specified date. The RAI MDS assessment indicated that Resident #001 displays the responsive behaviours of wandering, and resisting care.

Review of Resident #001's progress notes since admission was completed and several incidents of responsive behaviours were documented.

Staff members were interviewed regarding Resident #001's behaviour and identified specific responsive behavours. Inspector #556 interviewed the DOC who also stated that Resident #001 has responsive behaviours.

Following a review of Resident #001's care plan, it was noted that there is no indication that strategies are developed and implemented to respond to Resident #001 's behaviours in Resident #001's care plan.

As such the licensee failed to comply with O. Reg 79/10, s.53.(4)(b) whereby for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible. [s. 53. (4) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The inspection of the above mentioned critical incident of staff to resident abuse resulted in Inspector #556 reviewing the homes policy entitled Zero Tolerance of Abuse and Neglect #A11 effective September 2002 and revised September 2011. The Executive Director confirmed that the home is currently using policy #A11. Inspector #556 noted that the policy, #A11, does not contain procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate. As such, the licensee has failed to ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate. [s. 96. (b)]

WN #5: 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. As part of the inspection of the above mentioned critical incident Inspector #556 reviewed the internal investigation of the alleged staff to resident abuse that took place on a specified date and noted that the documentation refers to staff member S109 pushing resident #004 towards the dining room, and speaking inappropriately to resident #004. In addition staff member S109 was observed pushing resident #001 abruptly from a standing position down into a chair on two occasions during the noon meal, telling Resident #001 to get out of the dining room, and then blocking resident #001 from returning to the dining room.

In an interview with the ED, and the EBA, the EBA stated that there was a second resident involved in the incident who was also abused by staff member S109.

The EBA stated that the SDM of resident #001 was not called about the incident of staff to resident abuse until four days after the incident; and was unaware of whether a call was made to the SDM of resident #004.

A review of Resident #001's medical record indicates that a call was made to Resident #001's SDM four days after the incident. A review of resident #004's medical record indicates that there is no documentation of the occurrence of the incident, and no documentation that the substitute decision maker (SDM) was called regarding the incident of abuse.

As such the licensee did not ensure that the SDM of Resident #001, or Resident #004 were notified within 12 hours upon becoming aware of an alleged, suspected or witnessed incident of abuse. [s. 97. (1) (b)]

Issued on this 22nd day of January, 2014

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

Wendy Patterson