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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 19, 2016	2016_290551_0013	012181-16, 014155-16	Critical Incident System

Licensee/Titulaire de permis

TAMINAGI INC.
05 Loiselle Street CP Box 2132 Embrun ON K0A 1W1

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

SARSFIELD COLONIAL HOME
2861 Colonial Road P.O. Box 130 Sarsfield ON K0A 3E0

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): June 20, 21, 22 and 24, 2016.

The following logs were inspected: 012181-16 (an allegation of resident to resident abuse) and 014155-16 (related to a resident's fall).

During the course of the inspection, the inspector(s) spoke with Residents, Personal Support Workers (PSWs), Registered Nursing Staff, the RAI co-ordinator, the Physiotherapist Assistant, a Pharmacist, the Director of Care (DOC), the General Manager (GM) and the Administrator.

During the course of the inspection, the inspector(s) reviewed health care records, reviewed specific policies and procedures, observed staff to resident and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Falls Prevention
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **5 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	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. 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. 1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents:
(b) clearly set out what constitutes abuse and neglect
(d) contained an explanation of the duty under section 24 to make mandatory reports
(e) contained procedures for investigating and responding to alleged, suspected or witnessed
abuse and neglect of residents
(h) dealt with any additional matters as may be provided for in the regulations

The "Zero Tolerance to Abuse & Neglect" policy, effective September 24, 2014 was provided to the inspector by the DOC.

i) The policy did not clearly set out what constitutes abuse and neglect in that:

The definition of emotional abuse does not clearly set out that as per O. Reg 79/10, s. 2 (1):

- (a) the emotional abuse is performed by anyone other than a resident
- (b) the emotional abuse is performed by a resident that causes alarm or fear to another resident where the resident performing the abuse understands and appreciates their consequences

The definition of physical abuse does not clearly set out that as per O. Reg 79/10, s. 2 (1) physical abuse means:
- (a) the use of physical force is by anyone other than a resident
- (b) administering or withholding a drug for an inappropriate purpose
- (c) the use of physical force is by a resident and causes physical injury to another resident

The definition of sexual abuse does not clearly set out that as per O. Reg 79/10, s. 2 (1):
- (a) the sexual abuse is directed towards a resident by a licensee or a staff member
- (b) the sexual abuse is directed towards a resident by a person other than a licensee or staff member
- subject to subsection (3) for the purposes of the definition of "sexual abuse" in subsection (1), sexual abuse does not include, (b) the consensual touching, behaviour or remarks of a sexual nature between a resident and a licensee or staff member that is in the course of a sexual relationship that began before the resident was admitted to the long-term care home or before the licensee or staff member became a licensee or staff member

The definition of verbal abuse does not clearly set out that as per O. Reg 79/10, s. 2 (1):
- (a) that the verbal abuse is made by anyone other than a resident
- (b) that the verbal abuse is made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences

ii) The policy did not contain an explanation of the duty under section 24 to make mandatory reports.

As per LTCHA 2007, c. 8, s. 24 (1) A person who has reasonable grounds to suspect that any of the following had 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 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 or the Local Health System Integration Act, 2006.

The policy speaks to reporting abuse and neglect only.

iii) The policy did not contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents, as per O.Reg. 79/10 s. 97 (1), (2) and (3):

As per O. Reg 79/10, 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 to the resident or that causes distress to the resident that could be potentially detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident
(2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

The policy states that the findings of the preliminary inquiry must be conveyed immediately to the Administrator to decide notification of next of kin, within 12 hours.

iv) The policy did not deal with any additional matters as may be provided for in the regulations

As per LTCHA, 2007, c. 8, s. 76 (2) every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. Note that "no person" is defined as "all staff" in subsection (1).

The home's policy indicated that "all employees, volunteers, residents and their Power of

Attorneys will be oriented to the Zero Tolerance to Abuse Policy within one month of hire/admission".

A VPC was issued under LTCHA, 2007, c. 8, s. 20 (2) on April 6, 2016 (2016_284545_0005). The Administrator stated that she is working to revise the policy to ensure that it is compliant with the legislation. [s. 20. (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 the policy to promote zero tolerance of abuse and neglect of residents meets the legislative requirements, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a PASD described in s. 33 (1) is used to assist a resident with a routine activity of daily living only if the use of the PASD is included in the resident's plan of care.

As per LTCHA, 2007, s. 8, s. 33 (1) this section applies to the use of a personal assistance service device (PASD) if the PASD has the effect of limiting or inhibiting a

resident's freedom of movement and the resident is not able, either physically or cognitively, to release themself from the PASD.

Resident #001 was admitted to the home on a specified date. Several hours after admission, the resident was found to have fallen and was taken to hospital.

According to resident #001's health care record, he/she was using a transport wheelchair upon return from the hospital, and was provided with a tilt wheel chair (owned by the home) for better positioning and comfort.

During the course of the inspection, resident #001 was observed sitting in the wheel chair with a buckled front closing seat belt and with a table top applied.

On June 24, 2016, resident #001 was asked by RPN #109 to remove the table top, then the seat belt. Resident #001 was unable to physically or cognitively remove the seat belt or table top.

The resident's health care record was reviewed, and it does not indicate when the seat belt and table top were initiated or the reason for their implementation.

RN #102 stated that resident #001 was nervous to fall and felt safe when the seat belt and table top were applied. The RN stated that the resident could not undo either. The DOC stated that the resident used the seat belt, but not the table top, at all times when seated in the wheelchair. The DOC stated that the seat belt was to prevent the resident from sliding forward.

Resident #001's written plan of care does not indicate that he/she uses a front closing seat belt and table top when seated in the wheelchair. [s. 33. (3)]

2. The licensee has failed to ensure that the use of a PASD has been approved by a person with the authority to do so.

Resident #001 has been using one of the home's wheelchairs since returning from the hospital.

During the course of the inspection, resident #001 was observed sitting in the wheel chair with a buckled front closing seat belt and with a table top applied.

A review of the resident's health care record indicated that the use of seat belt was not approved by any of the persons as specified in LTCHA 2007, c. 8, s. 33 (3). [s. 33. (4) 3.]

3. The licensee has failed to ensure that the use of a PASD has been consented to by the resident's substitute-decision maker (SDM).

Resident #001 has been using one of the home's wheelchairs since returning from the hospital.

During the course of the inspection, resident #001 was observed sitting in the wheel chair with a buckled front closing seat belt and with a table top applied.

A review of the resident's health care record indicated that the use of seat belt was not approved by resident #001's SDMs. [s. 33. (4) 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 the use of any PASD is included in resident #001 plan of care, is approved and is consented to, to be implemented voluntarily.

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. The licensee had failed to ensure that strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

Resident #002 was admitted to the home on a specified date. Approximately three weeks later, the resident was sent to the hospital and was subsequently discharged from the home.

Resident #002 demonstrated responsive behaviours on a daily basis, including: wandering, moving furniture, striking residents, urinating on the floor, laying in other residents' beds, exit seeking and refusing and resisting care.

The home's BSO Champion completed an initial assessment on the resident ten days after his/her admission to the home and developed strategies to respond to resident #002's responsive behaviours. A review of the resident's health care record indicates that the BSO Champion's strategies were not implemented, including:

i) The BSO Champion's strategy to respond to resident #002's responsive behaviours was to have the resident's bowels assessed regarding constipation.

As per the Medication Administration Record (MAR), resident #002 was given a specific medication on three occasions as the resident had gone three days without a bowel movement according to the Daily Flow Sheet.

The Daily Flow Sheet indicates that on two occasions, resident #002 was on day three without a bowel movement, and according to the MAR, the Bowel Care Protocol/Medical Directives were not followed.

According to the resident's MAR, he/she was given a specific bowel medication on a specific day. The resident's response to the intervention is not documented. Resident #002 did not have a documented bowel movement. On the fourth day without a bowel movement, there is no documentation in the progress notes or on the MAR to indicate that resident #002 received any bowel intervention. It was not until several days later that RN #115 charted that it appeared that the resident was on day 8 without a bowel movement, and that the PSW reported that he had found evidence of a bowel movement in the resident's washroom three days prior. Resident #002 received a bowel

intervention by the nurse on that day.

ii) The BSO Champion's strategy to respond to resident #002's responsive behaviours was to have the resident's urine collected and tested to rule out a urinary tract infection (UTI).

No documentation was found in the resident's health care record to indicate that this strategy was implemented, and that urine was collected and tested as per recommendation from the BSO Champion.

In a follow-up assessment, the BSO Champion again stated to continue to follow-up regarding constipation and the possibility of a UTI.

iii) The BSO Champion's strategy to respond to resident #002's responsive behaviours was to complete Behaviour Mapping.

According to the resident's health care record, Behaviour Mapping was not consistently completed. During a four day period, Behavior Mapping was not completed over half of the time, and according to progress note entries, resident #002 was displaying responsive behaviours, including on a specific day when the resident required the administration of a when necessary (prn) medication, followed by a stat dose of a specific medication. In a follow up assessment on a specific date, the BSO Champion stated to continue behaviour monitoring, and as per the Behaviour Mapping sheets, this strategy was not implemented until four days later.

iv) During a follow-up assessment, the BSO Champion's strategy to respond to resident #002's responsive behaviours was to consider a referral to the Royal Ottawa Hospital (ROH) psychiatry program.

The DOC stated that the physician wanted to stabilize the resident and wanted to resume a medication which had been discontinued before referring resident #002 to the psychogeriatrician.

A review of the Geriatric Psychiatry Assessment completed prior to the resident's admission to the home, indicated that a specific medication had been discontinued. Seven days after the resident's admission, the specific medication was reordered. The specific medication was discontinued seven days later.

Resident #002 was not referred to psychogeriatrics. [s. 53. (4) (b)]

2. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, that 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.

Resident #002 was admitted to the home on a specified date. Approximately three weeks later, the resident was sent to the hospital and was subsequently discharged from the home.

According to a review of the resident's health care record the resident demonstrated responsive behaviours on a daily basis.

The resident's responses to the interventions were not consistently documented, including:

i) In a progress note entry written by the DOC on a specific day, resident #002 was described as displaying responsive behaviours. On this day, the resident required the administration of a when necessary (prn) medication, followed by a stat dose of a specific medication, and a higher dose of a medication was ordered starting that evening.

The telephone order was received at 1340 hours according to the physician's order sheet. The specific medication that was ordered to be given at a higher dosage is signed as given at 1600 hours. No follow-up note was written to document the resident's response to the stat dose of a specific medication and to the increase in the dosage of a specific medication.

Near the end of her shift, RN #113 wrote a progress note stating that the resident had been demonstrating responsive behaviours and that she was not made aware.

ii) The MAR indicates that resident #002 received a prn dose of a specific medication on a specific date during the night. The resident's response to the intervention is not documented, except for three hours later when the resident was described as agitated and resistive to care.

iii) According to the resident's MAR, he/she was given a prn dose of a specific medication on a specific date during the late evening. The resident's response to the

intervention is not documented.

iv) According to the resident's MAR, he/she was given a specific bowel medication on a specific day. The resident's response to the intervention is not documented. Resident #002 did not have a documented bowel movement. On the fourth day without a bowel movement, there is no documentation in the progress notes or on the MAR to indicate that resident #002 received any bowel intervention. It was not until several days later that RN #115 charted that it appeared that the resident was on day 8 without a bowel movement, and that the PSW reported that he had found evidence of a bowel movement in the resident's washroom three days prior. Resident #002 received a bowel intervention by the nurse on that day. [s. 53. (4) (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 for each resident demonstrating responsive behaviours strategies are developed and implemented to respond to these behaviours, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy under section 29 of the Act deals with how consent to the use of PASDs as set out in section 33 of the Act is to be obtained and documented.

The home's policy titled Restraints, effective date January 2010 was reviewed.

Under Planning for Restraint Use, the policy states:

2. If a restraint is required, consent will be obtained by the family/POA using the Restraint Information Consent or Refusal Form.
5. A doctor's order will be obtained prior to the initial application of a restraint.

The policy speaks only to the use of restraints and does not mention the use of PASDs. [s. 109. (e)]

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 home's written policy under section 29 of the Act deals with how consent to the use of PASDs as set out in section 33 of the Act is to be obtained and documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to the resident in accordance with the directions for use specified by the prescriber.

On a specified day, resident #002 was admitted to the home, and was ordered three medications to be administered at 0800 and 1600 hours. On the day of admission at 1600 hours, these medication are identified on the MAR as "N" which is the code used for Not Delivered.

According to a Classic Care Pharmacist, the pharmacy received the medication orders on the day of admission at 1427 hours, and the medications were delivered to the home at approximately 1800 hours.

A progress note entry on the day of admission stated that resident #002 was displaying behaviours after supper and had struck a co-resident and a PSW.

The DOC indicated that there was no documentation to verify that resident #002 received the prescribed 1600 hours medications on the day of admission.

Seven days after the resident's admission, the physician changed the dosage of a specific medication. The times for medication administration were not specified in the order, and according to the MAR, the prescribed times were 0800 and 1600 hours.

According to a Classic Care Pharmacist, the order was processed on the same day at 1631 hours.

On the specific day, resident #002 received the specific medication at 0800 hours as prescribed. The order was changed to a new dose at 1631 hours, and the medication was delivered to the home at approximately 1800 hours.

On the specific date at 1600 hours, the specific medication is identified on the MAR as "N" which is the code used for Not Delivered, and the specific medication at 1600 hours is not signed as administered as prescribed. According to the MAR, resident #002 did not receive the medication as prescribed until 0800 hours on the following day.

After supper that evening, resident #002 was described as very busy, not responsive to redirection and resistive to care.

The DOC indicated that there was no documentation to verify that resident #002 received the specific medication at 1600 hours as prescribed on the specific day. [s. 131. (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 drugs are administered to the resident in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: 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. (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 the results of the abuse investigation were reported to the Director

A Critical Incident Report (CIR) was submitted to the Director under the LTCHA on a specific date detailing two incidents that had occurred between resident #002 and resident #003 and resident #004.

According to the home's internal Incident Reports, the incident between resident #002 and resident #003 occurred on a specific date after supper, and the incident between resident #002 and resident #004 occurred next day in the afternoon.

According to resident #002's health care record, following the incident between resident #002 and resident #004, the paramedics and police were called, and the resident was sent to the hospital. The resident was discharged from the home.

As of June 28, 2016, the CIR was not amended to report the results of the home's investigation to the Director. [s. 23. (2)]

WN #7: 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. The licensee has failed to ensure that a person who had reasonable grounds to suspect that, abuse of a resident by anyone, has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

A Critical Incident Report (CIR) was submitted to the Director on a specific date detailing two incidents that had occurred between resident #002 and resident #003 and resident #004. According to the CIR, resident #002 was found in resident #004's room and had covered resident #004's head with blankets; resident #002 was found lying in resident #003's bed and #003 was yelling.

The DOC stated that she had reasonable grounds to suspect that abuse had occurred in both incidents and submitted a CIR.

According to the home's internal Incident Report, PSW #116 was alerted to the incident between resident #002 and resident #003 when she heard resident #003 screaming, and PSW #116 reported the incident to RN #113.

In a progress note, written as a late entry RN #113 indicated that she witnessed the incident when resident #002 covered resident #004's head with a blanket.

RN #113 was in charge of the home when the incident occurred. The incidents of suspected abuse that occurred between resident #002 and resident #003 and between resident #002 and resident #004 were not reported to the Director immediately; they were not reported until two and three days later, respectively. [s. 24. (1)]

WN #8: 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 notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

A CIR was submitted to the Director indicating that resident #002 was found lying in resident #003's bed and #003 was yelling.

The DOC stated that she had reasonable grounds to suspect that abuse had occurred and submitted a CIR.

The home's internal Incident Report indicated that the incident between resident #002 and resident #003 occurred on a specific date in the afternoon.

According to a progress note entry, resident #003's SDM was notified of the incident one day later on the evening shift which was not within 12 hours. [s. 97. (1) (b)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that before discharging a resident under subsection 145 (1) (the resident's requirements for care have changed and as a result, the home cannot provide a sufficiently secure environment to ensure the safety of the resident of the safety of persons who come into contact with the resident), the licensee provided a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

Resident #002 was admitted to the home on a specified date. Approximately three weeks later, the resident was sent to the hospital and was subsequently discharged from the home.

During his/her admission to the home, resident #002 had multiple incidents of responsive behaviours.

The home's BSO Champion completed an assessment on the resident on and listed

specific strategies to respond to resident #002's responsive behaviours. The BSO Champion followed up on two other occasions. According to the DOC, the physician wanted to stabilize the resident before referring him/her to psychogeratrics.

On a specific day, resident #002 was found lying in resident #003's bed.

The next day, resident #002 was found covering resident #004's head with a blanket.

Following this incident involving resident #002 and resident #004, the paramedics and police were called, and resident #002 was sent to the hospital.

On a specific date, a progress note entry in resident #002's chart stated that the DOC had phoned the resident's SDM to discuss that the home was not anticipating readmitting the resident. According to a progress note on the same day, the CCAC phoned the DOC to confirm that resident #002 was discharged from the home.

The DOC stated that the home could not provide the care that the resident needed.

The DOC confirmed that she did not provide written notice to the resident, the resident's SDM, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. [s. 148. (2)]

Issued on this 19th day of July, 2016

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

Original report signed by the inspector.