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 4, 2018	2018_726724_0005	025325-18	Critical Incident System

Licensee/Titulaire de permis

City of Toronto
55 John Street Metro Hall, 11th Floor TORONTO ON M5V 3C6

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

Seven Oaks
9 Neilson Road SCARBOROUGH ON M1E 5E1

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

MIKO HAWKEN (724)

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 17, 18, 19, 20, 21 & 24, 2018

The following intake(s) were inspected:
Log #: 025325-18 - Critical Incident Report related to suspected abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Nurse Manager (NM), Registered Nurses (RN), Registered Practical Nurses (RPN), Practical Care Aides (PCA), residents and family members.

During the course of the inspection, the inspector observed resident care and staff to resident interactions, observed resident to resident interactions, and reviewed identified residents' clinical records, relevant licensee's policies and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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. 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 :

The licensee has failed to ensure that there is a written policy in place that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

The home's written policy, "Zero Tolerance for Abuse and Neglect"(Section 03) stated: The Long Term Homes and Services Division will not tolerate the abuse and/or neglect of any resident by any person. It is everyone's responsibility to report actual, suspected or alleged incident of resident abuse and or neglect. The procedure stated:

A. Investigation and Reporting:

-Inform the RN/RPN immediately on becoming aware of any and every alleged, suspected or witnessed incidents of abuse or neglect in order to commence an immediate investigation and reporting. (ALL STAFF)
-Assess and examine the resident(s) immediately; document results and follow up action in the progress notes. (RN/RPN)
-Inform the Nurse Manager/RN-in-Charge immediately once an allegation, suspicion, witnessed of abuse and/or neglect has been made (this includes informing the on-call manager). Continuously monitor resident and report unusual behavior/reaction to abuse and /or neglect to physician; document in the progress notes and update Care Plan. (RN/RPN)

The home submitted Critical Incident Report (CIR) on a specific date and time to the Director related to suspected staff to resident abuse. The CIR report indicated there were injuries found on resident #001 which was reported on a specific date by an personal Care Assistant (PCA) #101 to Registered Nurse (RN) # 104. The CIR was prompted by the home on a specific date after the substitute Decision Maker (SDM) visited the home with concerns.

A record review of resident #001's records indicated an assessment was completed on a specific date by RN #104. A review of the assessment indicated the resident sustained injuries to specific areas. No additional information was noted in the assessment.

A review of the homes internal Resident Incident Report with an incident date of a specific date and time indicated that PCA #101 had found the resident with injuries to specific areas. The incident report also documented that an assessment was completed and resident #001 said they were injured.

In an interview with PCA #101 on a specific date stated they had reported and shown RN

#104 the injuries on specific date and time frame. PCA #101 also stated they had told RN #104 the resident had stated they were assaulted. The PCA also indicated the injuries were to specific to areas on resident #001.The PCA #101 stated they were not aware of what RN #104 did with the information but acknowledged that this was alleged or suspected abuse.

In an interview on a specific date with RN #104 indicated, PCA #101 reported the injuries and the allegations of alleged abuse. RN #104 indicated they assessed resident #001 and documented it in a specific document. RN #104 further indicated that on a specific date and time frame, they failed to document the assessment findings and follow up actions in the progress notes. RN #104 stated on a specific date, they completed the homes internal Resident Incident Report that indicated the alleged abuse reported by PCA #101 on specific date. RN #104 also stated they did not inform the charge RN working on the specific date and time frame as there were too many things going on at the time on the unit.

In an interview with NM #107 on a specific date they acknowledged that RN #104 failed to comply with the home's written policy on Zero Tolerance for Abuse and Neglect where RN #104 failed to commence an immediate investigation, report the alleged abuse to the in-charge RN, as well as failed to document the results and follow up action in the progress notes of alleged abuse reported by PCA #101. Therefore the licensee failed to ensure their written policy that promotes zero tolerance of abuse and neglect of residents, was complied with.

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 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,, to be implemented voluntarily.

WN #2: 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 :

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
(ii) Neglect of a resident by the licensee or staff, or
(iii) Anything else provided for in the regulations.

The home submitted Critical Incident Report (CIR) on a specific date and time to the Director related to suspected staff to resident abuse. The CIR report indicated that injuries were found on resident #001's specific areas, which was reported on a specific date and time frame by a Personal Care Assistant (PCA) #101 to Registered Nurse (RN) # 104. The CIR was prompted by the home on a specific date after the substitute Decision Maker (SDM) visited the home with concerns.

A review of the homes internal Resident Incident Report with an incident date of a specific date and time indicated that PCA #101 had found the resident with injuries to specific areas. The incident report also documented that an assessment was completed and resident #001 said they were injured.

A review of resident #001's clinical records revealed a certain assessment with a specific date noting injuries to specific areas by RN #104. No other clinical documentation was found for the specific date regarding this incident.

In an interview with PCA #101 on a specific date stated they had reported and shown RN #104 the injuries during the on a specific date and time period. PCA #101 also stated they had told RN #104 that resident #001 had alleged abuse. The PCA also stated the injuries were found on specific areas of resident #001. PCA #101 stated they were not aware of what RN #104 did with the information but acknowledged that this would be suspected or alleged abuse.

In an interview with RN #104 on a specific date stated they were familiar with resident #001 and had seen the injuries on resident #001 in the dining room during dinner on a specific date. RN #104 said that PCA #101 reported resident #001 had injuries and that resident #001 indicated to them they had been abused. RN #104 stated they completed assessment to document the injuries but at the time did not immediately investigate the allegations as there was so many things going on at the time on the unit. RN #104 indicated they completed an internal home incident report on a specific date with information that resident #001 had reported to PCA #101 they had been abused and confirmed that would be indicative of alleged or suspected abuse.

In an interview with Nurse Manager (NM) #107 on a specific date confirmed the injuries found on resident #001 and their report of alleged abuse. NM #107 further indicated that RN #104 failed to commence an immediate investigation into the abuse allegations by resident #001.

On a specific date in an interview with the Clinical Nurse Manager (CNM) #106 they confirmed the injuries and the response from resident #001 would be consistent with alleged or suspected abuse and that RN# 104 failed to commence an immediate investigation. Therefore, the licensee failed to ensure that the suspected abuse of resident #001 by anyone, that the licensee knows of, or that is reported, is immediately investigated.

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, (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; (b) appropriate action is taken in response to every such incident; and (c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with,, to be implemented voluntarily.

WN #3: 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 :

The licensee 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.

The home submitted Critical Incident Report (CIR) on a specific date and time to the

Director related to suspected staff to resident abuse. The report indicated that injuries were found on resident #001 specific area by a PCA #101 who reported the finding to RN #104 on a specific date. The CIR was prompted by the home on a specific date after the substitute Decision Maker (SDM) visited the home with concerns.

According to resident #001's progress notes, on a specific date and time, the SDM and family came to visit resident #001, and found them with injuries to specific areas stated that resident #001 had told them they were abused. The progress notes also noted the SDM had spoken to RN #102, who did not see any written notes regarding any injuries or incident but the only documentation that noted the injuries was the day after the reported incident date from a registered staff.

On a specific date in an interview with the SDM, stated they were never notified of the injuries, and the alleged abuse and only became aware of the injuries on their visit to the home on a specific date. During the visit they spoke with RN #102, and had discovered there was no report of it prior to a specific date.

On a specific date in an interview with PCA #101 stated they had reported and had shown RN #104 the injuries on a specific date, and that resident #001 alleged they had been abused. PCA #101 also stated that they were unaware of what RPN #104 did with this information.

A review of the home's internal incident report with a specific date and time, completed by RN #104 noted, resident #001 was discovered with injuries to specific areas. Resident #001 told the PCA #101 they did not know what happened but indicated they were abused. No other injuries were noted and the resident #001 denied pain. There was no indication in the incident report that the SDM was notified of this incident.

During an interview on a specific date with RN #104, on a specific date during a specific time frame that PCA #101 had reported the injuries and the alleged abuse claims made by resident #001 but failed to report this to the SDM.

In an interview on a specific date with in-charge unit RN #102, they acknowledged that PCA staff are to report any changes to resident's health status to the registered staff and the registered staff are to act on any alleged abuse made by residents as well as any physical signs of abuse seen on the resident. In-charge unit RN #102 stated that registered staff are to report changes to residents to the SDM but should report suspected abuse immediately to the SDM. In-charge unit RN #102 acknowledged that

RN #104 failed to report the alleged abuse to the SDM of resident #001.

In an interview on a specific date with Nurse Manager (NM) #107, acknowledged that RPN #104 failed to report the alleged abuse from resident #001 immediately to the SDM. Therefore the home failed to ensure the resident's SDM was immediately notified upon becoming aware of the alleged or suspected abuse of the resident that resulted in a injury to resident #001.

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 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,, to be implemented voluntarily.

Issued on this 21st day of December, 2018

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

Original report signed by the inspector.