Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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 20, 2019	2019_594746_0024	001096-19, 010835-19, 016547-19, 017433-19, 020106-19	Complaint

Licensee/Titulaire de permis

City of Toronto
c/o Seniors Services and Long-Term Care 365 Bloor Street East, 15th Floor TORONTO ON M4W 3L4

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

AMANDEEP BHELA (746), ANGIEM KING (644), SUSAN SEMEREDY (501)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 27, 28, 29, December 2, 3, 4, 5, 6, 9 and 10, 2019.

During this inspection the following intakes were inspected.

Three logs related to abuse.
One log related to personal support services and maintenance.
One log related to plan of care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Interim Director of Nursing (DON), Nurse Managers (NM), Medical Director, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Care Aide (PCA), Physiotherapist (PT), Occupational Therapist (OT), Resident Intake Clerk, Registered Practical Nurse-BSO, Nurse Consultant, Receptionist, Manager of Resident Services, Counsellor, Central East LHIN Placement Co-ordinator, residents and Substitute Decision Makers (SDM's).

During the course of the inspection, the inspector(s) conducted observations of staff and resident interactions and resident to resident interactions; reviewed health records, staffing schedules, home's complaint and critical incident system investigation records, and relevant policies and procedures.

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

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A review of the home's policy #RC-0305-00 titled "Zero Tolerance of Abuse and Neglect" published January 8, 2016, defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain. Examples of physical abuse are described and include rough handling. The procedure for reporting indicates registered staff are to inform the Nurse Manager/RN-in-Charge (RNIC) immediately once an allegation has been made. All managers are then to inform the Director of Nursing (DON), Administrator and General Manger immediately of the allegation. The RNIC/DON/Administrator are to notify the Ministry of Long-Term Care (MLTC) immediately that an alleged incident of abuse has become known and an investigation is underway.

The MLTC received complaints from resident #001 regarding physical abuse from PCA #115. During interviews with resident #001 on an identified date, they explained that personal care attendant (PCA) #115 was rough with them during care. The resident indicated they had reported the incident to the registered staff who was on duty at the time (RPN #138), Manager of Resident Services (MRS) #112, Nurse Manager (NM) #107, and Interim/Acting Director of Nursing (ADON) #108 and did not believe the issue had been resolved. The resident stated they thought the incident occurred on an identified date. The MLTC received a critical incident system (CIS) report the following month, related to the same incident.

Interviews with RPN #138 and NM#107 indicated they did not recognize the incident as an allegation of physical abuse even though they were aware the resident had complained of a PCA providing rough care which caused the resident to be in pain. The RPN and NM therefore did not report the incident to anyone else. An interview with ADON #108 indicated that after becoming aware of the situation immediately reported it to the Administrator who initiated a CIS report on an identified date.

An interview with Administrator #119 confirmed that the above incident was an allegation of physical abuse and the home had failed to immediately notify the MLTC of an allegation of abuse as required in their policy. [s. 20. (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 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 :

1. The licensee has failed to ensure that every alleged incident of abuse of a resident by anyone that the licensee knows of, was immediately investigated and appropriate action was taken.

The Ministry of Long-Term Care (MLTC) received complaints from resident #001 regarding physical abuse from PCA #115. During interviews with resident #001 on two identified dates, they explained that personal care attendant (PCA) #115 was rough with them during care and believed this was in retaliation to an incident that occurred a few days previous when the resident had complained about the same PCA to Nurse Manager #107. The resident stated that PCA #106 had also been in the room when the rough

handling occurred, and they thought it had occurred on a specific identified date. The resident also indicated they had reported the incident to the Manager of Resident Services (MRS) #112, Nurse Manager (NM) #107, and Interim/Acting Director of Nursing (ADON) #108 and did not believe the issue had been resolved.

A review of the home's policy #RC-0305-00 titled "Zero Tolerance of Abuse and Neglect" published January 8, 2016, defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain. Examples of physical abuse are described and include rough handling. The procedure for investigation and reporting indicates registered staff are to inform the Nurse Manager/RN-in-Charge (RNIC) immediately once an allegation has been made. All managers are then to conduct a full investigation and document all significant information pertaining to the incident including who was involved and statements from all witnesses.

A review of resident #001's progress notes revealed registered practical nurse (RPN) #138 documented that on an identified date, resident #001 complained that PCA #115 was rough when they provided care, resulting in discomfort. It was then documented that both RPN #138 and PCA #115 went and talked with resident #001 to explain and ask why the resident did not complain when others gave the same type of care. Another progress note on an identified date, written by the same RPN, indicated resident #001 was still upset about the incident that occurred on an identified date, and did not want PCA #115 to provide care for them in the future.

A review of a progress note written on an identified date, by another registered staff member indicated the resident was still upset about an incident that occurred on an identified date and had already complained to a nurse manager and director of nursing. A further progress note indicated that on an identified date, ADON #108 wrote that resident #001 reported an incident that occurred on an identified date when two PCAs were in their room and one was rough which had been reported to NM #107. This note indicated that the Administrator was informed, a critical incident system (CIS) report was completed and in investigation was to be initiated.

An interview with NM #107 indicated they did not investigate the incident that occurred on the identified date because they did not think it was an allegation of abuse as the resident was not harmed. The NM #107 indicated a meeting between the resident, the MRS, PCA #115 and themselves took place on an identified date, and supplied a copy of notes taken during this meeting. A review of the notes indicated resident #001 did not want PCA #115 assigned to them because the PCA was rough when providing care. The

notes indicated the PCA explained again the process needed for providing care and the fact that the resident does not have concerns when other PCAs provide the same such care. The outcome was for two persons to be present to support resident #001 in hygiene care.

A review of the CIS report submitted to the MLTC regarding this incident indicated that an amendment was made on an identified date, stating that the investigation was completed and because one of the staff members that the resident stated was in the room at the time was not on the schedule on the identified date, the allegation could not be substantiated. A review of the home's schedule on three identified dates indicated PCA #115 and #106 were both on the schedule on an identified date which was the same day RPN #138 documented the incident occurred.

An interview with ADON #108 indicated an investigation of the incident had been conducted by NM #107. The ADON stated they had checked payroll records and made the note regarding being unable to substantiate the allegation on the CIS report. The ADON confirmed they had not interviewed any staff members or checked the resident's progress notes to clarify the actual date of occurrence.

An interview with PCA #106 who was in the room at the time of the incident, indicated they recalled the incident but did not believe PCA #115 was intentionally causing resident #001 discomfort but was trying to provide care. PCA #106 stated they had tried to calm the resident by explaining PCA #115 was simply trying to help the resident. PCA #106 also indicated no one from the home had interviewed them regarding the incident.

An interview with PCA #115 indicated they recalled both incidents described by resident #001. The PCA indicated that neither incident was intended to harm, mistreat or in any way be disrespectful to resident #001. The PCA also indicated that the meeting that took place on the identified date, with the resident, NM #107, the social worker and themselves was initiated by them because of the uncomfortable feeling the PCA was having due to the resident's continued complaints regarding them.

An interview with Administrator #119 confirmed that the above incident was an allegation of physical abuse. The Administrator acknowledged that the staff did not immediately investigate or take appropriate action to resolve the matter. [s. 23. (1) (b)]

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 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) is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home received individualized personal care, including hygiene care and grooming, on a daily basis.

The Ministry of Long-Term Care (MLTC) received complaints from resident #001 regarding rough handling from PCA #115. During interviews with resident #001 they explained that PCA #115 was rough with them during peri-care on an evening shift late on an identified date. The resident described they were being washed by PCA #115 and it was so painful they were crying and in pain for three days.

An interview with NM #107 indicated that they were aware of this incident and resident #001 often complains during the specific care. According to NM #107, resident #001 has their preferred PCAs.

An interview with PCA #106 who was in the room with PCA #115 during the above-mentioned incident, indicated resident #001’s is sensitive when receiving that specific

care, and the resident often makes a noise during care. During the particular incident the PCA recalled the resident made a statement about concerns with care.

An interview with PCA #115 confirmed that during the incident the resident stated, concerns with care and was also aware that resident #001 has problems with sensitivity when receiving that specific care.

Interviews with PCA #109 and #111 indicated they were aware resident #001's was very sensitive and when receiving that specific care, one had to be very gentle. Both PCAs stated resident #001 has never complained about their method of providing that specific care.

A review of resident #001's written plan of care last updated on an identified date,did not indicate any individualized personal care needs related to sensitivity.

An interview with ADOC #137 confirmed that resident #001's plan of care does not include any individualized interventions to address the resident's specific care needs. The ADOC stated that PCAs who provide care without the resident complaining could be interviewed to see what interventions they use to make the care less uncomfortable for the resident.

The home failed to ensure that resident #001 received individualized personal care. [s. 32.]

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 each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis, to be implemented voluntarily.

Issued on this 7th day of January, 2020

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

Original report signed by the inspector.