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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
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 # / Registre no	Type of Inspection / Genre d'inspection
Oct 21, 2013	2013_162109_0034	O-000824-13	Critical Incident System

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
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

SUSAN SQUIRES (109), NICOLE RANGER (189)

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 10, 12, 16, 17, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Nurse manager, Social Worker, Registered Nursing Staff, Personal Support Workers, Private Care Staff, Resident

During the course of the inspection, the inspector(s) observed the care unit, conducted a record review for resident # 1, reviewed policies and procedures

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

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)

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.

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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. 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 :

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1. The licensee failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone and neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
Staff interview of 11 direct care staff, registered nurse Manager, Social Worker and 2 private sitters indicated that all staff on the unit had concerns and suspicions of sexual abuse of resident # 1 by a family member.

The administrator had knowledge from a previous Long Term Care Home that the resident's family member was under suspicion of abusing the resident. The administrator reported to the Inspectors that she had received a telephone call followed by an email titled "Alleged Abuse" from the previous LTCH administrator where the resident was previously residing. The previous LTCH administrator provided information about concerns of abuse of the resident by a family member. The previous LTCH's administrator indicated in the email that he was hoping that Seven Oaks could use the information to help them in protecting this resident if there is abuse happening.

During the time the resident was in the home, the family member exhibited behaviors which caused the staff at Seven Oaks to be suspicious about the safety of the resident while the family member was in attendance.

The home did not report the suspicion and the information upon which it was based to the Director. The Administrator told the Inspectors that she did not report her concerns because she believed that she needed proof that abuse was occurring and they did not believe that they had evidence of abuse. The administrator further stated that she believed the information from the other homes to be hearsay [s. 24. (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 a person who has reasonable grounds to suspect the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect residents from abuse by anyone.

Staff interview of 11 direct care staff, RN Manager, Social Worker and 2 private sitters indicated that all staff on the unit had concerns and suspicions of abuse of resident # 1 by a family member.

Resident # 1 was admitted to the home with medical conditions which included dementia and alcohol abuse. Resident was identified as incapable according to a capacity assessment. According to the home's administrator within the second night that resident # 1 was in the home, the home's staff were concerned about the behaviors and actions of the family member. The administrator reported within ten days the family member placed locks on the cabinet doors and would not let the staff enter the room when he/she was visiting the resident. The administrator stated that the staff were on "High Alert" whenever this resident's family member visited.

According to the progress notes on identified dates and confirmed through staff interview, the staff observed situations which caused them to be concerned. Staff interview further revealed that the staff did not check on the resident for safety even though they were all suspicious of the family members' actions with the resident.

Record review revealed that the family member took the resident out of the home for hours at a time on numerous occasions during the resident's stay at the home and after the home became suspicious of abuse. The resident returned to the home on numerous occasions smelling of alcohol and appearing to be intoxicated. Even after the family member was asked to stop providing alcohol because of the psychotropic medications that the resident was receiving, he/she continued to give the resident alcohol while on outings.

The home's administrator called a care conference with the family member on an identified date to place restrictions on visits and to implement a head-to toe skin assessment on the resident and assessing the resident for signs of alcohol consumption. The skin assessments were completed throughout the resident's stay at the home. Record review revealed that the home implemented a behavior tracking tool to monitor the resident's behavior after she/he returned from outings with the family member. The behavior tracking revealed that the resident experienced an increase in responsive behaviors after being with the family member. This assessment was completed on the resident after every outing with the suspected

family member throughout her/his stay at the home.

The home placed visiting restrictions on the family member. The restrictions which the home placed on the family member were not enforced as indicated by numerous violations of the restrictions by the family member on progress notes for identified dates which were after the restrictions were applied.
The administrator reported to the Inspectors that she had received a telephone call followed by an email titled "Alleged Abuse" on an identified date from the previous LTCH administrator where the resident was previously residing. The previous LTCH administrator provided information about concerns of abuse of the resident by a family member. The previous LTCH's administrator indicated in the email that he was hoping that Seven Oaks could use the information to help them in protecting this resident if there is abuse happening. The administrator stated to inspectors while the information received from the previous LTCH was suspicious, she still considered the information to be hearsay.

Staff interview revealed that several staff members observed the family member acting inappropriately with the resident and indicated that this behavior was odd and made them feel uncomfortable. A progress note on an identified date indicates that the nurse observed the resident's family member acting inappropriately with the resident.

Staff interview revealed that the family member often stayed in the room while the staff was providing personal care to the resident which the staff indicated was inappropriate and made them feel uncomfortable. A progress note from an identified date indicates that the family member ordered the staff to wash the resident upon return from outings. The staff member reported this to the nurse of the home.

Inspectors were told that an individual overheard a telephone conversation between the resident and the family member in which the resident made alarming comments to the family member. The RPN confirmed to the Inspector that the individual told her/him about this conversation.

Staff interview revealed that the resident was heard telling an individual inappropriate things about the family member. Record review revealed that the resident suffers from dementia and has confused beliefs about the relationship. Progress note from an identified date states that the resident told the staff that the family member was the

spouse and not the child.

All staff reported that they had suspicions of abuse of the resident from the family member. Staff reported to inspectors that management was made aware of the concerns. The family member discharged the resident from the home. [s. 19. (1)]

WN #3: 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 failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents is complied with.

The homes policy # RC-0305-02 titled Zero Tolerance of Abuse & Neglect of Residents: Reporting and Investigating states that all incidents of suspected abuse must be reported to MOHLTC.

The staff were suspicious that resident # 1 was being abused by a family member. The staff interviews revealed that the staff had been trained on the home's policy to promote zero tolerance of abuse. The homes policy was not complied with. The suspicion of abuse was not reported to MOHLTC. [s. 20. (1)]

Issued on this 14th day of November, 2013

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