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
Jun 13, 2019	2019_702197_0013	031318-18, 032462-18, 001104-19, 005421-19, 008409-19, 009402-19	Critical Incident System

Licensee/Titulaire de permis

Sherwood Park Manor
1814 County Road #2 East BROCKVILLE ON K6V 5T1

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

Sherwood Park Manor
1814 County Road #2 East BROCKVILLE ON K6V 5T1

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

JESSICA PATTISON (197)

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): May 1-3, 6-9, 21-24, 2019

The following logs were completed as part of this inspection:
Log 031318-18 - related to Critical Incident (CI) 2640-000010-18, fall of a resident with injury resulting in a transfer to hospital
Log 032462-18 - related to CI 2640-000013-18, fall and injury of a resident resulting in transfer to hospital
Log 001104-19 - follow-up inspection related to a compliance order regarding the application of seat belt restraints
Log 005421-19 - related to CI 2640-000004-19, alleged staff to resident abuse
Log 008409-19 - related to CI 2640-000005-19, improper/incompetent treatment of a resident
Log 009402-19 - related to CI 2640-000006-19, alleged staff to resident abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Physiotherapist, the Scheduler, Administrative Assistants, the Resident and Family Services Manager, Maintenance staff, Registered Nurses, Registered Practical Nurses, Personal Support Workers and residents.

The inspector observed resident care and reviewed resident health care records, as well as the home's policy related to abuse and neglect, internal investigation files, education records and critical incident reports.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
6 WN(s)
3 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
O.Reg 79/10 s. 23.	CO #003	2018_765541_0017	197

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 they complied with their zero tolerance of abuse and neglect policy.

On a specified date, a Critical Incident Report (CIR) was submitted by the home alleging verbal, emotional and physical abuse of resident #045 by staff member #124. The CIR indicated that an internal investigation was conducted and staff member #124 was terminated the day before the CIR was submitted.

Upon review of the investigation file, it was noted that there were previous incidents of alleged resident abuse involving staff member #124 over an approximate six month period. The inspector interviewed multiple staff members and the following information was reported:

1. On a specified date, staff member #115 indicated that they witnessed staff member #124 being verbally and emotionally abusive to resident #049 when providing care.

Staff member #115 indicated that they spoke to the other PSW staff members (names could not be recalled) at the time and they indicated they would report the incident to management. Staff member #115 indicated they thought it had been dealt with at the time. The Director of Care (DOC) indicated to the inspector that they did not become aware of this incident until a later date via email.

2. Staff member #106 submitted a written report to the Administrator indicating that they overheard staff member #124 being verbally aggressive with resident #006 on a specified date. That same day, staff member #124 wrote an account of what happened and indicated that they said something inappropriate to the resident.

During an interview with the Administrator, they indicated that they did not feel this incident fit the definition of abuse and did not report to the Director.

3. On another date, staff member #106 documented that staff member #119 had come to them to report that staff member #124 was overheard yelling at resident #017 and that staff member #117 had also witnessed the incident. Staff member #117 later wrote an account of the incident indicating that staff member #124 yelled at resident #017 and that the resident was upset and not eating. They wrote that staff member #124 then took the resident away and was yelling at them about taking their shirt off.

Staff member #106 indicated that they had submitted their written note to the DOC by

putting it in their mailbox in the office, as they were not in the home that day. Staff member #117 indicated they did not report the incident at the time because there were registered nursing staff present and stated that they felt they would have reported the incident. Staff member #117 later submitted their account of what happened when asked by the DOC.

4. On another occasion, staff member #120 stated that they witnessed staff member #124 swear at resident #045. Staff member #124 was witnessed to aggressively remove the resident's shirt and was noted to be rough the resident while providing their care. Staff member #120 indicated that resident #045 was yelling at the staff member to leave them alone but staff member #124 did not acknowledge the resident's request and continued with the care.

During an interview with staff member #120, they indicated that they did not report the incident at the time. They stated they later wrote a letter to the DOC approximately two week later detailing what had happened.

Other incidents involving staff member #124 that were reported to the inspector through multiple interviews with staff included the following:

5. Staff member #119 stated that one day staff member #124 told the bath person not to bathe resident #003 first as per the resident's wishes. This was stated to be a punishment for the resident as they had reported staff member #124 and had gotten them in trouble. Staff member #119 said the bath person and did what staff member #124 directed them to do.

6. Staff member #118 stated that they witnessed staff member #124 yell at resident #045 and specified the comments that were made.

7. Staff member #118 also reported that they witnessed staff member #124 drop resident #011's call bell down the side of the bed so that they could not reach it to ring for assistance. Staff member #124 reported to staff member #118 that they did this because they were frustrated with the resident.

8. Staff member #117 indicated that they were working with staff member #124 providing care to resident #012. The resident indicated they did not want their shirt taken off, but staff member #124 was witnessed to forcefully attempt removing resident #012's shirt against their wishes. Staff member #117 stated they tried to tell the staff member the

shirt did not have to be changed, but they would not listen. As a result, resident #012 became upset and combative.

The above incidents, # 5 through 8, were not reported as per the home's policy. No specific dates and some staff names could not be recalled by the staff being interviewed.

The home's policy titled "Zero Tolerance of Abuse and Neglect", last reviewed September 4, 2018, includes the following definitions for abuse:

Verbal abuse means (a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth that is made by anyone other than a resident.

Physical abuse means (a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Emotional abuse means (a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgment or infantilization that are performed by anyone other than a resident.

The home's Zero Tolerance of Abuse and Neglect policy outlines the investigation and reporting requirements, which staff did not comply with as follows:

Step 3, Page 3
- Reports by staff and board members under this policy, and third party reports of abuse or neglect, will be immediately investigated in accordance with the investigation procedures in Part B, Section Two: Reporting and Notifications.

The home did not comply with this step of their policy related to incident #3 as the DOC was provided with the allegation of resident abuse and the licensee was unable to provide evidence of an investigation into staff member #124 until approximately one month later.

Step 7, Page 4
- The resident and the resident's SDM, if any, will be notified of the results of the

investigation immediately upon the completion of the investigation.

The home's investigation into incident #4 concluded with the termination of staff member #124 as the home found that the staff member had been witnessed abusing residents #017, 045 and 049. The DOC indicated that the home did not notify these residents and/or their SDM's of the outcome of their investigation.

Reporting, Page 7
- An alleged or witnessed incident of abuse or neglect shall be immediately reported to the charge nurse, supervisor, department manager or Administrator as appropriate
- Sherwood Park Manor is obliged to file a report about an alleged or witnessed incident of abuse or neglect to the MOHLTC, they can contact the Ministry in various ways as outlined in the Policy on Staff Reporting and Whistle-blower Protection (A-2-205)

Staff members did not follow the home's policy in that there was no evidence that incidents 1 and 4-8 were immediately reported to the charge nurse, supervisor, department manager or Administrator immediately when they felt staff member #124 was being abusive towards residents.

The licensee did not file reports to the MOHLTC regarding incidents #1 and 3 that they became aware of when investigating incident #4.

Individual (Supervisor/Manager/Registered Nurse) receiving the report of alleged abuse or neglect, Page 9
- Notify the Administrator or Director of Care (DOC) or Assistant Director of Care (ADOC). If after hours, notify the DOC/ADOC on call immediately upon receipt of the report of alleged, witnessed or unwitnessed abuse or neglect, and initiate the investigation.
- Immediately notify the SDM or person requested by the resident of the incident if the resident is harmed, and within 12 hours of all other situations of alleged or witnessed abuse or neglect. LTCHA Section 97(1)(a) and (b).

In incident #3, staff member #106 did not notify the Administrator/DOC/ADOC immediately upon receipt of the alleged resident abuse.

In incidents #1, 3 and 4, the DOC informed the inspector that the resident's SDMs were not notified of the alleged abuse.

In summary, the licensee did not comply with multiple sections of their policy related to Zero Tolerance of Abuse and Neglect.

The following non-compliances are also being issued related to the incidents of alleged, suspected and witnessed resident abuse by staff member #124:

WN #2 related to LTCHA 2007, s. 23(1)(a) in that when an allegation of resident abuse was made, the licensee was unable to show evidence that an investigation began immediately.

WN #3 related to LTCHA 2007, s. 24(1) in that persons who had reasonable grounds to suspect abuse of a resident, did not immediately report the suspicsion and the information upon which it was based to the Director.

WN #4 related to O. Reg. 79/10, s. 97 in that resident SDM's were not notified when the licensee became aware of the alleged, suspected or witnessed incidents of abuse and also, that those same SDM's were not notified of the results of the abuse investigation, immediately upon completion. [s. 20. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

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 when there was alleged abuse of resident #017, the allegation was immediately investigated.

As per WN # 1, the home submitted a Critical Incident Report (CIR) related to a staff to resident abuse on a specified date. This CIR indicated that there was an allegation of verbal, physical and emotional abuse to a resident by staff member #124.

Upon review of the investigation file, the inspector saw a note dated approximately six week prior to the CIR, written by staff member #106. This note was an account of PSW #119 reporting to them that staff member #124 was verbally abusive towards residents. Specifically, it was mentioned that on one shift, staff member #124 was overheard by staff yelling at resident #017.

During an interview with staff member #106, they stated that they put this letter in the DOC's mailbox the day it was written.

During an interview with the DOC, they stated that staff member #106 provided their written notes shortly after the incident occurred, but was unable to provide evidence of an investigation until approximately one month later, when another allegation of abuse was made related to staff member #124.

Therefore, the allegation of abuse towards resident #017 was not investigated immediately. [s. 23. (1) (a)]

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 allegations of resident abuse and neglect are investigated immediately, to be implemented voluntarily.

WN #3: 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 the person who had reasonable grounds to suspect that residents #006, 017, 045 and 049 had been abused by a staff member, immediately report the suspicion and the information upon which it was based to the Director.

As per WN #1, alleged abuse of residents #006, 017, 045 and 049 (incidents #1-4) by staff member #124 were not immediately reported to the Director as required. [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 that the person who had reasonable grounds to suspect that residents have been abused or neglected by a staff member, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #4: 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).

s. 97. (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. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #045, #049 and #017's SDM and any other person specified by the resident were notified within 12 hours of becoming aware of any other alleged, suspected or witnessed abuse of the residents.

As per WN #1, the home submitted a Critical Incident (CI) Report outlining the witnessed abuse of resident #045 by staff member #124 that occurred on a specified date.

Upon review of the home's investigation file, it was noted that staff had witnessed other incidents where staff member #124 had been abusive towards resident #049 and resident #017 on two other occasions.

During an interview with the DOC, they indicated that the SDMs for these resident's were not notified of the abuse allegations. [s. 97. (1) (b)]

2. The licensee has failed to ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the abuse investigation immediately upon the completion of the investigation.

As per WN #1, the Director of Care informed the inspector that the SDM's for residents #017, 045 and 049 were not informed of the outcome of the abuse investigation. [s. 97. (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 resident's SDMs and any other person specified by the resident are notified within 12 hours of becoming aware of any other alleged, suspected or witnessed abuse of residents and that these SDM's are also notified of of the outcome of the home's abuse investigation, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The following finding is further evidence to support CO #001 first issued on January 7, 2019, during complaint inspection 2018_702197_0026. The incident below occurred before the compliance due date of April 30, 2019.

The licensee has failed to ensure that the plan of care for resident #002 was provided to the resident as specified in the plan.

On a specified date, resident #002's POA signed a "Resuscitation Directives" form as part of the resident's plan of care that indicated their wishes for care.

At the bottom of the same form, there was a statement that said, "In the event of any other acute medical emergency such as a stroke, fracture, respiratory distress or sudden, unexpected change in consciousness, 911 will be called and resident will be transferred to the hospital".

On a specified date, the DOC submitted a Critical Incident Report to the Ministry of Health and Long-Term Care indicating that that there had been a change in resident #002's condition two days prior and neither the POA, nor attending Physician where contacted. Resident #002 was assessed by the Physician the day the CIR was submitted and sent to hospital for further assessment. The Physician informed the home later that day that the resident had a specific diagnosis.

The progress notes for resident #002 were reviewed for a specified period.

RN # 107 documented assessments for the resident that took place at three different times on the first date the resident's condition changed. The RN stated they passed the information onto the next shift to monitor the resident.

Resident #002 was noted to have a specific symptom by the evening RPN and they noted that medications were not given since the resident was sleeping.

The following morning, the Physiotherapist (PT) assessed resident #002 due to their reported change in condition. During a phone interview with the PT, they stated that it was one of the Physiotherapy Assistants (PTA) who asked them to assess the resident. There was no formal referral and the PT was unsure which staff member had told the PTA that the resident needed to be reassessed.

RPN #113 assessed resident #002 and documented further notes related to the resident's change in condition, however, indicated that the resident appeared to be improving.

RN #108 charted that they had assessed resident #002 and noted that the resident appeared to have symptoms of a specified condition.. The RN documented that staff stated this happened the day before. The RN noted that they had done vitals and asked the evening RN to call the family and update them.

During an interview with RN #108, they stated that during the assessment of the resident they seemed ok, but the resident was noted to be having certain symptoms. The RN stated they assumed that one of the shifts prior had notified the family of the change in condition and it wasn't until the end of their shift when reviewing the progress notes that they realized no one had called. The RN then asked the oncoming evening RN (#109) to call the family.

RN #109 indicated to the inspector that they worked two evening shifts during the specified time. They recalled coming in and asked the RN if there were any issues. The RN said that resident #002 had certain symptoms, which they thought was possibly due to another condition. They stated there was no mention at that point of any other potential condition. Resident #002 had been given a specified medication earlier in the day, so RN #109 wondered if that was the reason for the resident's change in condition. They stated that when they came in for their shift the next day, they were informed by PSW staff that the resident had a specified diagnosis. They were then asked by the day RN to call the family to notify them. RN #109 documented that it had still not officially been determined that the resident had the specified diagnosis, but it appeared likely based on the symptoms the resident was displaying. They documented that they would start a specified assessment and continue to monitor for further changes.

An agency night RN documented that it has been noted on evenings that perhaps this resident has had a specified diagnosis. Resident was noted to have specified symptoms at that time.

The Director of Care (DOC) documented two days after the onset of the change in condition, that they became aware of the change in resident status that morning and called the Physician to come in and assess the resident. The DOC, RN and Physician were all noted to be present for the assessment. The resident's substitute decision-maker (SDM) was contacted and discussed the resident's plan of care. The decision was then made to send resident #002 to the hospital for further assessment. During an interview with the DOC, they stated that the resident started to present with symptoms two days before they were made aware of the situation. The registered staff noted the change in condition and did assess the resident, but did not call the POA or Physician, and did not call 911 at the onset of symptoms. The DOC indicated there was some confusion among staff and some thought the previous shift had notified the SDM.

Therefore, the home did not provide the care that was specified in the resident's plan of care in relation to the "Resuscitation Directives" form that was signed by the resident's SDM. [s. 6. (7)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

1. The licensee has failed to comply with the following requirement of the LTCHA:

It is a condition of every licence that the licensee shall comply with every order made under this Act.

On January 4, 2019, Compliance Order (CO) #003 from inspection number 2018_765541_0017 was made under O. Reg. 79/10, s. 23 and stated:

The licensee must be compliant with O. Reg 79/10 s. 23.

Specifically, the licensee shall:

a. Ensure that when residents #021, #045 and #049 and any other resident who has a seat belt applied, the device is applied according to manufacturer's instructions.

b. Ensure that all staff members who are responsible for the application and assessment of resident seat belts, receive education to ensure they are aware of how to apply the device, the risks associated with improperly applied seat belts and what action to take when a seat belt is not applied appropriately. This education shall be documented.

The amended compliance due date was March 31, 2019.

The licensee completed step a., in that for all specified residents and all others observed during the inspection period, who had a seat belt applied, the device was applied according to manufacturer's instructions.

The licensee failed to complete step b., in that not all staff members responsible for the application and assessment of resident seat belts, received education to ensure they are aware of how to apply the device, the risks associated with improperly applied seat belts and what action to take when a seat belt is not applied appropriately.

During the inspection, the Director of Care (DOC) gave the inspector a copy of the education provided to staff regarding the application of seat belts, as well as a list of all staff that had received the education and on what dates.

Upon review of the dates, it was noted that 5 staff members received their education after the compliance due date of March 31, 2019.

When comparing the list provided by the DOC to the list of staff working in the home, the inspector identified two staff members that were noted to be casual employees in the home. When asked, the DOC indicated they had not yet received their education related to the safe application of seat belts. [s. 101. (3)]

Issued on this 17th day of June, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) : JESSICA PATTISON (197)

Inspection No. / No de l'inspection : 2019_702197_0013

Log No. / No de registre : 031318-18, 032462-18, 001104-19, 005421-19, 008409-19, 009402-19

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Jun 13, 2019

Licensee / Titulaire de permis : Sherwood Park Manor
1814 County Road #2 East, BROCKVILLE, ON, K6V-5T1

LTC Home / Foyer de SLD : Sherwood Park Manor
1814 County Road #2 East, BROCKVILLE, ON, K6V-5T1

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Alfred O'Rourke

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To Sherwood Park Manor, you are hereby required to comply with the following order (s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d’ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall be compliant with LTCHA 2007, s. 20(1).

Specifically, the licensee shall:

(a) Review the policy titled "Zero Tolerance of Abuse and Neglect" to ensure that it is up-to-date and in-line with the requirements set out in the LTCHA, 2007 and O. Reg. 79/10 related to the abuse and neglect of residents. The home shall ensure there is a documented record including the date of the review, the names of the staff members who reviewed the policy and any changes made.

(b) Provide and document education to all staff in the home related to recognizing resident abuse and neglect and the related mandatory reporting requirements, as per the reviewed Zero Tolerance of Abuse and Neglect policy. The documentation shall include a copy of the education provided, the employee's names and date the education was provided.

(c) As per the reviewed Zero Tolerance of Abuse and Neglect policy:

- Report to the Director immediately, any alleged, suspected or witnessed resident abuse or neglect.

- Immediately investigate any alleged, suspected or witnessed resident abuse and/or neglect.

- Notify the SDM's, and any other person identified by the resident, for residents #017, 045 and 049 related to the allegations of abuse by staff member #124 and the outcome of the home's abuse investigation. Ensure that all future allegations of resident abuse and/or neglect and outcomes of the corresponding investigations are reported to the resident's SDM(s).

Grounds / Motifs :

1. The licensee has failed to ensure that they complied with their zero tolerance of abuse and neglect policy.

On a specified date, a Critical Incident Report (CIR) was submitted by the home alleging verbal, emotional and physical abuse of resident #045 by staff member #124. The CIR indicated that an internal investigation was conducted and staff

member #124 was terminated the day before the CIR was submitted.

Upon review of the investigation file, it was noted that there were previous incidents of alleged resident abuse involving staff member #124 over an approximate six month period. The inspector interviewed multiple staff members and the following information was reported:

1. On a specified date, staff member #115 indicated that they witnessed staff member #124 being verbally and emotionally abusive to resident #049 when providing care.

Staff member #115 indicated that they spoke to the other PSW staff members (names could not be recalled) at the time and they indicated they would report the incident to management. Staff member #115 indicated they thought it had been dealt with at the time. The Director of Care (DOC) indicated to the inspector that they did not become aware of this incident until a later date via email.

2. Staff member #106 submitted a written report to the Administrator indicating that they overheard staff member #124 being verbally aggressive with resident #006 on a specified date. That same day, staff member #124 wrote an account of what happened and indicated that they said something inappropriate to the resident.

During an interview with the Administrator, they indicated that they did not feel this incident fit the definition of abuse and did not report to the Director.

3. On another date, staff member #106 documented that staff member #119 had come to them to report that staff member #124 was overheard yelling at resident #017 and that staff member #117 had also witnessed the incident. Staff member #117 later wrote an account of the incident indicating that staff member #124 yelled at resident #017 and that the resident was upset and not eating. They wrote that staff member #124 then took the resident away and was yelling at them about taking their shirt off.

Staff member #106 indicated that they had submitted their written note to the DOC by putting it in their mailbox in the office, as they were not in the home that

day. Staff member #117 indicated they did not report the incident at the time because there were registered nursing staff present and stated that they felt they would have reported the incident. Staff member #117 later submitted their account of what happened when asked by the DOC.

4. On another occasion, staff member #120 stated that they witnessed staff member #124 swear at resident #045. Staff member #124 was witnessed to aggressively remove the resident's shirt and was noted to be rough the resident while providing their care. Staff member #120 indicated that resident #045 was yelling at the staff member to leave them alone but staff member #124 did not acknowledge the resident's request and continued with the care.

During an interview with staff member #120, they indicated that they did not report the incident at the time. They stated they later wrote a letter to the DOC approximately two week later detailing what had happened.

Other incidents involving staff member #124 that were reported to the inspector through multiple interviews with staff included the following:

5. Staff member #119 stated that one day staff member #124 told the bath person not to bathe resident #003 first as per the resident's wishes. This was stated to be a punishment for the resident as they had reported staff member #124 and had gotten them in trouble. Staff member #119 said the bath person and did what staff member #124 directed them to do.

6. Staff member #118 stated that they witnessed staff member #124 yell at resident #045 and specified the comments that were made.

7. Staff member #118 also reported that they witnessed staff member #124 drop resident #011's call bell down the side of the bed so that they could not reach it to ring for assistance. Staff member #124 reported to staff member #118 that they did this because they were frustrated with the resident.

8. Staff member #117 indicated that they were working with staff member #124 providing care to resident #012. The resident indicated they did not want their shirt taken off, but staff member #124 was witnessed to forcefully attempt removing resident #012's shirt against their wishes. Staff member #117 stated

they tried to tell the staff member the shirt did not have to be changed, but they would not listen. As a result, resident #012 became upset and combative.

The above incidents, # 5 through 8, were not reported as per the home's policy. No specific dates and some staff names could not be recalled by the staff being interviewed.

The home's policy titled "Zero Tolerance of Abuse and Neglect", last reviewed September 4, 2018, includes the following definitions for abuse:

Verbal abuse means (a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth that is made by anyone other than a resident.

Physical abuse means (a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Emotional abuse means (a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgment or infantilization that are performed by anyone other than a resident.

The home's Zero Tolerance of Abuse and Neglect policy outlines the investigation and reporting requirements, which staff did not comply with as follows:

Step 3, Page 3
- Reports by staff and board members under this policy, and third party reports of abuse or neglect, will be immediately investigated in accordance with the investigation procedures in Part B, Section Two: Reporting and Notifications.

The home did not comply with this step of their policy related to incident #3 as the DOC was provided with the allegation of resident abuse and the licensee was unable to provide evidence of an investigation into staff member #124 until approximately one month later.

Step 7, Page 4
- The resident and the resident's SDM, if any, will be notified of the results of the investigation immediately upon the completion of the investigation.

The home's investigation into incident #4 concluded with the termination of staff member #124 as the home found that the staff member had been witnessed abusing residents #017, 045 and 049. The DOC indicated that the home did not notify these residents and/or their SDM's of the outcome of their investigation.

Reporting, Page 7
- An alleged or witnessed incident of abuse or neglect shall be immediately reported to the charge nurse, supervisor, department manager or Administrator as appropriate
- Sherwood Park Manor is obliged to file a report about an alleged or witnessed incident of abuse or neglect to the MOHLTC, they can contact the Ministry in various ways as outlined in the Policy on Staff Reporting and Whistle-blower Protection (A-2-205)

Staff members did not follow the home's policy in that there was no evidence that incidents 1 and 4-8 were immediately reported to the charge nurse, supervisor, department manager or Administrator immediately when they felt staff member #124 was being abusive towards residents.

The licensee did not file reports to the MOHLTC regarding incidents #1 and 3 that they became aware of when investigating incident #4.

Individual (Supervisor/Manager/Registered Nurse) receiving the report of alleged abuse or neglect, Page 9
- Notify the Administrator or Director of Care (DOC) or Assistant Director of Care (ADOC). If after hours, notify the DOC/ADOC on call immediately upon receipt of the report of alleged, witnessed or unwitnessed abuse or neglect, and initiate the investigation.
- Immediately notify the SDM or person requested by the resident of the incident if the resident is harmed, and within 12 hours of all other situations of alleged or witnessed abuse or neglect. LTCHA Section 97(1)(a) and (b).

In incident #3, staff member #106 did not notify the Administrator/DOC/ADOC

immediately upon receipt of the alleged resident abuse.

In incidents #1, 3 and 4, the DOC informed the inspector that the resident's SDMs were not notified of the alleged abuse.

In summary, the licensee did not comply with multiple sections of their policy related to Zero Tolerance of Abuse and Neglect.

The following non-compliances are also being issued related to the incidents of alleged, suspected and witnessed resident abuse by staff member #124:

WN #2 related to LTCHA 2007, s. 23(1)(a) in that when an allegation of resident abuse was made, the licensee was unable to show evidence that an investigation began immediately.

WN #3 related to LTCHA 2007, s. 24(1) in that persons who had reasonable grounds to suspect abuse of a resident, did not immediately report the suspicsion and the information upon which it was based to the Director.

WN #4 related to O. Reg. 79/10, s. 97 in that resident SDM's were not notified when the licensee became aware of the alleged, suspected or witnessed incidents of abuse and also, that those same SDM's were not notified of the results of the abuse investigation, immediately upon completion.

The decision to issue this as a compliance order is based on the following:

There was actual risk of harm to residents given that there were multiple incidents of witnessed abuse of residents by staff member #124.

The scope was determined to be pattern as the witnessed abuse occurred in several locations, with multiple residents being affected by the same staff member's abusive behaviour.

The licensee's compliance history showed previous non-compliance to the same subsection. On March 23, 2017, under inspection # 2017_505103_0010, LTCHA 2007, s. 20(1) was issued as a VPC. (197)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 13, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 13th day of June, 2019

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Jessica Pattison

Service Area Office / Bureau régional de services : Ottawa Service Area Office