Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 5, 2016	2016_282543_0006	004700-16	Critical Incident System

Licensee/Titulaire de permis

ST. JOSEPH'S GENERAL HOSPITAL ELLIOT LAKE
70 Spine Road ELLIOT LAKE ON P5A 1X2

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

ST. JOSEPH'S MANOR
70 SPINE ROAD ELLIOT LAKE ON P5A 1X2

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

TIFFANY BOUCHER (543)

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): Febraury 24-26, 2106

The Following log was inspected during this inspection: 004700-16.

Throughout the inspection, the inspector directly observed the delivery of care and services to resident, directly observed various meal services, reviewed resident health care records, reviewed staffing patterns and reviewed various home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Administrative Assistant (AA), Personal Support Workers, Police Constable

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

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A critical incident (CI) related to alleged staff to resident sexual abuse was reported to the Director. According to the CI, PSW #102 allegedly sexually abused resident #001. The CI described that resident #001 stated to PSW #103, that PSW #102 had touched them in an inappropriate manner.

Throughout the inspection, Inspector #543 identified numerous non-compliances related to the duty to protect, and are as follows:

1) Inspector #543 reviewed the home's written documentation (Interdisciplinary Progress notes) related to the incident which revealed that RN #108 did not interview resident #001 until the day after it was reported to them. Further documentation provided by the Administrator confirmed that the initial investigation had not commenced until the day after the allegation. The Administrator did not follow up with the incident until approximately one week later.

During an interview with the Administrator, they confirmed that the investigation related to the incident has not commenced immediately. The Administrator also confirmed that they did not speak with PSW #102, who was involved in the alleged staff to resident sexual abuse until approximately one week later, stated they were on holidays.

In an interview with RN #108, they stated that it was the home’s expectation that all investigations related to abuse or alleged abuse that occurs in the home is initiated immediately.

According to the LTCHA 2007, s. 23, every licensee of a long-term care home shall ensure that, every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated.

2) Written documentation (Interdisciplinary Progress notes), indicated that RN #108 had not contacted the resident's SDM to inform them of the allegations of staff to resident abuse until approximately 22 hours after it was reported to RN #108.

According to O. Reg. 79/10, s. 97 (a), 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, 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.

3) Inspector #543 entered the home on a particular date for the purpose of inspecting this CI, at which point it was identified that the police had not been contacted related to the alleged staff to resident sexual abuse.

Written documentation provided by the Administrator indicated that they notified the police 10 days after the incident.

In order to comply with O. Reg. 79/10, s. 98, every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

4) Inspector #543 reviewed the home's Zero Tolerance of Abuse and Neglect policy (NUM VII-7) policy and it was identified that the policy did not address situations that may lead to abuse and neglect of residents and how to avoid such situations.

In an interview with the Administrator, they confirmed that their policy did not address any situations that may lead to abuse and neglect and how to avoid such situations.

According to O. Reg. 79/10, s. 96 (e) ii, every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, identifies the training and retraining requirements for all staff, including, situations that may lead to abuse and neglect and how to avoid such situations.

5) The Inspector reviewed the home's Program evaluation related to their Zero Tolerance of Abuse and Neglect policy which identified that the policy was evaluated twice in the year 2015. The first evaluation was done in March 2015 (no specific date indicated) and again in June 2015 (no specific date indicated). This evaluation did not indicate what changes were made, nor did it identify who participated in the evaluation.

During an interview with the Administrator, they confirmed that their evaluation did not contain what changes were made or who participated in the evaluation.

According to O. Reg. 79/10, s. 99, every licensee of a long-term care home shall ensure

that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared.

6) The Inspector reviewed the home's Zero Tolerance of Abuse and Neglect policy (NUM VII-7) last reviewed March 2015. This policy stated that the staff of the home would immediately investigate reports of abuse or neglect, in accordance with the investigation procedures. This policy also identified that, the staff would coordinate with the Supervisor/Manager to fully investigate and complete documentation of all known details of the reported incident.

During an interview with the Administrator, they confirmed that the investigation related to the incident that was reported has not commenced immediately. The Administrator also confirmed that they did not speak with PSW #102, who was involved in the alleged staff to resident abuse approximately one week later, stated they were on holidays.

In an interview with RN #108, they stated that it was the home's expectation that all investigations related to abuse or alleged abuse that occurred in the home were initiated immediately.

7) The Inspector reviewed the home's Zero Tolerance of Abuse and Neglect policy (NUM VII-7) last reviewed March 2015. The licensee failed to comply with their policy for these reasons:

a) Written documentation (Interdisciplinary Progress notes), indicated that RN #108 had not contacted the resident's SDM to inform of the allegations of staff to resident abuse until approximately 22 hours after the alleged abuse was reported.

b) Written documentation provided by the Administrator indicated that they notified the police, 10 days later after the incident.

c) The Inspector and the SAO Manager interviewed the Administrator. During the interview, the Administrator stated that staff involved in any alleged resident abuse would be relieved of their duties until an investigation was completed. The Administrator also confirmed that the PSW #102, who allegedly abused resident #001 was not relieved of their duties, and had worked providing care to residents after the alleged abuse was reported to the Ministry.

The Inspector reviewed the home's Zero Tolerance of Abuse and Neglect policy (NUM VII-7) with a reviewed date of March 2015. This policy stated that the Administrator/Director of Care shall ensure that the alleged perpetrator shall not have any unnecessary contact with the resident during the investigation.

In order to comply with the LTCHA, s. 20 (1), the licensee 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.

8) The Inspector reviewed the home's tracking system for mandatory training for 2015, specifically for PSW #102 which revealed that the home's User Education Summary indicated that the this staff member did not complete the required mandatory training for 2015. The home's Zero Tolerance of Abuse and Neglect policy (NUM VII-7) was reviewed in March 2015 and June 2015, and all staff were required to review the updated policy as part of the annual retraining. The Inspector identified that PSW #102 had not completed the mandatory training. In fact, 54% of all staff had not completed the mandatory training related to the home's policy.

In an interview with AA #101, they confirmed that the home's Abuse policy was updated twice in the year 2015, and that all staff was required to review the new policy as part of training in the home. They also confirmed that PSW #102 had not completed the training as required.

Throughout the inspection, the Inspector reviewed documentation, the licensee's Zero Tolerance of Abuse and Neglect policy (NUM VII-7) and interviewed various individuals and identified a pattern of inaction on the part of the licensee to ensure that residents are protected from abuse and neglect. [s. 19. (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 every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported were immediately investigated.

A critical incident related to alleged staff to resident sexual abuse that was reported to the Director. PSW #103 reported to the charge RN #108 that resident #001 reported that PSW #102 had allegedly touched them in an inappropriate manner.

Inspector #543 reviewed the home's written documentation (Interdisciplinary Progress notes) related to the incident which revealed that RN #108 did not interview resident #001 until the day after the incident. Further documentation provided by the Administrator confirmed that the initial investigation into the alleged sexual abuse had not commenced until the day after the allegation. The Administrator did not follow up with the incident until approximately 10 days later.

During an interview with the Administrator, they confirmed that the investigation related to the incident that was reported had not commenced immediately. The Administrator confirmed that they had instructed the charge RN #108 to follow-up with the resident and the family. The Administrator also confirmed that they had not spoken with PSW #102, who was involved in the alleged staff to resident abuse until approximately 10 days later, stated they were on holidays.

The home's Zero Tolerance of Abuse and Neglect policy (NUM VII-7) policy noted that the most senior manager responsible or on duty or on call was responsible for ensuring all of the appropriate steps had been taken. Upon receiving notification of abuse allegations they would ensure an investigation and reporting process was underway by the staff person to whom the alleged abuse or neglect was reported. This policy also indicated that the home would immediately investigate allegations of abuse.

In an interview with RN #108, they stated that it was the home's expectation that all investigations related to abuse or alleged abuse that occurs in the home were initiated immediately.

In order to comply with the LTCHA 2007, s. 23, every licensee of a long-term care home shall ensure that, every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, are immediately investigated [s. 23. (1) (a)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Zero Tolerance of Abuse and Neglect policy (NUM VII-7) of residents identified situations that may lead to abuse and neglect and how to avoid such situations.

Inspector #543 reviewed the home's Zero Tolerance of Abuse and Neglect policy (NUM VII-7) policy and identified that it did not address situations that may lead to abuse and neglect of residents and how to avoid such situations.

In an interview with the Administrator, the Inspector informed them that their above mentioned policy did not address such situations that may lead to abuse and neglect of residents and how to avoid such situations. The Administrator went through the policy and could not locate the same, and confirmed that their policy did not address any situations that may lead to abuse and neglect and how to avoid such situations. [s. 96. (e)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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 home's Zero Tolerance of Abuse and Neglect policy (NUM VII-7) was complied with.

A critical incident (CI) related to alleged staff to resident sexual abuse was reported to the Director. According to the CI, PSW #102 allegedly sexually abused resident #001. The CI described that resident #001 stated to PSW #103, that PSW #102 had touched them in an inappropriate manner.

The Inspector reviewed the home's Zero Tolerance of Abuse and Neglect policy (NUM VII-7) last reviewed March 2015. This policy stated that the staff of the home would immediately investigate reports by staff and board members under this policy and third party reports of abuse or neglect, in accordance with the investigation procedures. This policy also identified that, the staff would coordinate with the Supervisor/Manager to fully investigate and complete documentation of all known details of the reported incident.

During an interview with the Administrator, they confirmed that the investigation related to the incident that was reported had not commenced immediately. The Administrator also confirmed that they had not spoken with PSW #102, who was involved in the alleged staff to resident abuse until approximately 10 days later, stated they were on holidays.

In an interview with RN #108, they stated that it was the home's expectation that all investigations related to abuse or alleged abuse that occurred in the home were to be initiated immediately.

The Inspector reviewed the home's Zero Tolerance of Abuse and Neglect policy (NUM VII-7) last reviewed March 2015. This policy stated that the resident's substitute decision maker (SDM), would be notified immediately of an allegation of abuse or neglect.

Written documentation (Interdisciplinary Progress notes), indicated that RN #108 had not contacted the resident's SDM to inform of the allegations of staff to resident abuse until approximately 22 hours after the alleged abuse was initially reported to the home.

The Inspector reviewed the home's Zero Tolerance of Abuse and Neglect policy (NUM VII-7) last reviewed March 2015. This policy stated that the individual (Supervisor/Manager/Registered Nurse), upon receiving the report of alleged abuse or neglect were to notify the police if the alleged, suspected or witnessed incident of abuse or neglect of a resident that may constitute a criminal offence.

Written documentation provided by the Administrator indicated that they notified the police, 10 days after the incident was reported.

The Inspector reviewed the home's Zero Tolerance of Abuse and Neglect policy (NUM VII-7) last reviewed March 2015. The policy stated that the employee may be subject to disciplinary action, up to and including termination and may be prosecuted to the full extent of the law. The home's Zero Tolerance of Abuse and Neglect policy (NUM VII-7)

stated that the Administrator/Director of Care shall ensure that the alleged perpetrator would not have any unnecessary contact with the resident during the investigation.

The Inspector and the SAO Manager interviewed the Administrator. During the interview, the Administrator stated that staff involved in any alleged resident abuse would be relieved of their duties until an investigation was completed. The Administrator also confirmed that PSW #102, who allegedly abused resident #001 was not relieved of their duties, and had worked providing care to residents after the alleged abuse was reported. [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 the Zero Tolerance of Abuse and Neglect policy (NUM VII-7) is complied with, specifically related to investigating allegations of abuse, notifying residents' SDM related to abuse/neglect, reporting an alleged or actual incident of abuse or neglect that may constitute a criminal offence to the police, and ensuring that no resident has unnecessary contact with an alleged perpetrator, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that 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, or caused distress to the resident that could potentially be detrimental to the resident' s health or well-being.

A critical incident (CI) related to staff to resident sexual abuse that was reported to the Director, 2016. According to the CI resident #001 stated to PSW #103, that PSW #102 had touched them in an inappropriate manner.

Written documentation (Interdisciplinary Progress notes), indicated that RN #108 had not contacted the resident's SDM to inform of the allegations of staff to resident abuse until approximately 22 hours later.

The Inspector review reviewed the home's Zero Tolerance of Abuse and Neglect policy (NUM VII-7) with a reviewed date of March 2015. This policy stated that the resident's substitute decision maker (SDM), would be notified immediately of an allegation of abuse or neglect. [s. 97. (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 a resident's SDM or any other person specified by the resident shall be notified 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, or caused distress to the resident that could potentially be detrimental to the resident' s health or well-being, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

A critical incident (CI) related to alleged staff to resident sexual abuse that was reported to the Director. According to the CI resident #001 stated to PSW #103, that PSW #102 had touched them in an inappropriate manner.

Inspector #543 entered the home on a particular date for the purpose of inspecting this CI, and spoke with the Administrator who identified that the police had not been contacted related to the alleged staff to resident sexual abuse.

Written documentation provided by the Administrator indicated that they notified the police 10 days after the incident was reported.

The above mentioned allegation, related to staff to resident sexual abuse to which the nature would be considered a criminal offence. Thus, in order to comply with O. Reg. 70/10, s. 98, the licensee of a Long-term Care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. [s. 98.]

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 appropriate police force is immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record of everything provided for in the annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents, including the date, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented, was promptly prepared.

The Inspector reviewed the home's Program Evaluation related to their Zero Tolerance of Abuse and Neglect policy which identified that the policy was evaluated twice in the year 2015. The first evaluation was done in March 2015 (no specific date indicated) and again in June 2015 (no specific date indicated). This evaluation did not indicate what changes were made, nor did it identify who participated in the evaluation. These forms indicated that for both review dates, there were areas in the program that required revisions and/or improvements and that the changes would have been reflected in the program. However, the specific changes that were made were not identified in the Program Evaluation Forms.

During an interview with the Administrator, they confirmed that their evaluation did not contain all of the information mentioned above, as required in the regulations. [s. 99. (e)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a written record of everything provided for in the annual evaluation of their Zero Tolerance of Abuse and Neglect policy, including the date, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented, is promptly prepared, to be implemented voluntarily.

Issued on this 19th day of May, 2016

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

Original report signed by the inspector.

Ontario

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

Ministére 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 sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	TIFFANY BOUCHER (543)
Inspection No. / No de l'inspection :	2016_282543_0006
Log No. / Registre no:	004700-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 5, 2016
Licensee / Titulaire de permis :	ST. JOSEPH'S GENERAL HOSPITAL ELLIOT LAKE 70 Spine Road, ELLIOT LAKE, ON, P5A-1X2
LTC Home / Foyer de SLD :	ST. JOSEPH'S MANOR 70 SPINE ROAD, ELLIOT LAKE, ON, P5A-1X2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	WILMA FLINKERT

To ST. JOSEPH'S GENERAL HOSPITAL ELLIOT LAKE, 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) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance under s. 19 (1) of the LTCHA. The plan is to include but not be limited to:

1-Develop a system to ensure the home's internal investigations related to every alleged, suspected or witnessed incident of abuse of a resident by anyone, is immediately and thoroughly investigated,

2-Developing and implementing a system to ensure that when an allegation of abuse or neglect is reported, that any residents, substitute decision maker (SDM), or any other person specified by the resident is notified as specified in the Ontario Regulation 79/10,

3-Developing and implementing a system to ensure that when an allegation of abuse or neglect is reported, that may constitute a criminal offence, that the appropriate police force is immediately notified,

4-Ensuring when an allegation of abuse is reported, that no resident has any unnecessary contact with the potential perpetrator, until any investigation is completed,

5-Training and/or retraining for all staff in the home on the revised policy, specifically related to the prevention of abuse and neglect, including notification requirements as identified in the Long-Term Care Homes Act, 2007 and Ontario Regulation 79/10.

6-Maintain a record of who completed the required retraining, when the retraining was completed and what the retraining entailed.

This plan shall be submitted in writing to Tiffany Boucher, Long Term Care Homes Nursing Inspector, Ministry of Health and Long Term Care, Long -Term Care Inspections Branch, Long- Term Care Homes Division, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564-3133 or email Tiffany.Boucher@ontario.ca. This plan must be submitted by May 13, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A critical incident (CI) related to alleged staff to resident sexual abuse was reported to the Director. According to the CI, PSW #102 allegedly sexually abused resident #001. The CI described that resident #001 stated to PSW #103, that PSW #102 had touched them in an inappropriate manner.

Throughout the inspection, Inspector #543 identified numerous non-compliances related to the duty to protect, and are as follows:

1) Inspector #543 reviewed the home's written documentation (Interdisciplinary Progress notes) related to the incident which revealed that RN #108 did not interview resident #001 until the day after it was reported to them. Further documentation provided by the Administrator confirmed that the initial investigation had not commenced until the day after the allegation. The Administrator did not follow up with the incident until approximately one week later.

During an interview with the Administrator, they confirmed that the investigation related to the incident has not commenced immediately. The Administrator also confirmed that they did not speak with PSW #102, who was involved in the alleged staff to resident sexual abuse until approximately one week later, stated they were on holidays.

In an interview with RN #108, they stated that it was the home's expectation that all investigations related to abuse or alleged abuse that occurs in the home is initiated immediately.

According to the LTCHA 2007, s. 23, every licensee of a long-term care home shall ensure that, every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, is immediately investigated.

2) Written documentation (Interdisciplinary Progress notes), indicated that RN #108 had not contacted the resident's SDM to inform of the allegations of staff to resident abuse until approximately 22 hours after it was reported to RN #108.

According to O. Reg. 79/10, s. 97 (a), 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, 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.

3) Inspector #543 entered the home on a particular date for the purpose of inspecting this CI, at which point it was identified that the police had not been contacted related to the alleged staff to resident sexual abuse.

Written documentation provided by the Administrator indicated that they notified the police 10 days after the incident.

In order to comply with O. Reg. 79/10, s. 98, every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

4) Inspector #543 reviewed the home's Zero Tolerance of Abuse and Neglect policy (NUM VII-7) policy and it was identified that the policy did not address situations that may lead to abuse and neglect of residents and how to avoid such situations.

In an interview with the Administrator, they confirmed that their policy did not address any situations that may lead to abuse and neglect and how to avoid such situations.

According to O. Reg. 79/10, s. 96 (e) ii, every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, identifies the training and retraining requirements for all staff, including, situations that may lead to abuse and neglect and how to avoid such situations.

5) The Inspector reviewed the home's Program evaluation related to their Zero Tolerance of Abuse and Neglect policy which identified that the policy was evaluated twice in the year 2015. The first evaluation was done in March 2015 (no specific date indicated) and again in June 2015 (no specific date indicated). This evaluation did not indicate what changes were made, nor did it identify who participated in the evaluation.

During an interview with the Administrator, they confirmed that their evaluation did not contain what changes were made or who participated in the evaluation.

According to O. Reg. 79/10, s. 99, every licensee of a long-term care home shall ensure that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared.

6) The Inspector reviewed the home's Zero Tolerance of Abuse and Neglect policy (NUM VII-7) last reviewed March 2015. This policy stated that the staff of the home would immediately investigate reports of abuse or neglect, in accordance with the investigation procedures. This policy also identified that, the staff would coordinate with the Supervisor/Manager to fully investigate and complete documentation of all known details of the reported incident.

During an interview with the Administrator, they confirmed that the investigation related to the incident that was reported has not commenced immediately. The Administrator also confirmed that they did not speak with PSW #102, who was involved in the alleged staff to resident abuse approximately one week later, stated they were on holidays.

In an interview with RN #108, they stated that it was the home's expectation that all investigations related to abuse or alleged abuse that occurred in the home were initiated immediately.

7) The Inspector reviewed the home's Zero Tolerance of Abuse and Neglect policy (NUM VII-7) last reviewed March 2015. The licensee failed to comply with their policy for these reasons:

a) Written documentation (Interdisciplinary Progress notes), indicated that RN #108 had not contacted the resident's SDM to inform of the allegations of staff to resident abuse until approximately 22 hours after the alleged abuse was reported.

b) Written documentation provided by the Administrator indicated that they notified the police, 10 days later after the incident.

c) The Inspector and the SAO Manager interviewed the Administrator. During

the interview, the Administrator stated that staff involved in any alleged resident abuse would be relieved of their duties until an investigation was completed. The Administrator also confirmed that the PSW #102, who allegedly abused resident #001 was not relieved of their duties, and had worked providing care to residents after the alleged abuse was reported to the Ministry.

The Inspector reviewed the home's Zero Tolerance of Abuse and Neglect policy (NUM VII-7) with a reviewed date of March 2015. This policy stated that the Administrator/Director of Care shall ensure that the alleged perpetrator shall not have any unnecessary contact with the resident during the investigation.

In order to comply with the LTCHA, s. 20 (1), the licensee 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.

8) The Inspector reviewed the home's tracking system for mandatory training for 2015, specifically for PSW #102 which revealed that the home's User Education Summary indicated the this staff member did not complete the required mandatory training for 2015. The home's Zero Tolerance of Abuse and Neglect policy (NUM VII-7) was reviewed in March 2015 and June 2015, and all staff were required to review the updated policy as part of the annual retraining. The Inspector identified that PSW #102 had not completed the mandatory training. In fact, 54% of all staff had not completed the mandatory training related to the home's policy.

In an interview with AA #101, they confirmed that the home's Abuse policy was updated twice in the year 2015, and that all staff was required to review the new policy as part of training in the home. They also confirmed that PSW #102 had not completed the training as required.

Throughout the inspection, the Inspector reviewed documentation, the licensee's Zero Tolerance of Abuse and Neglect policy (NUM VII-7) and interviewed various individuals and identified a pattern of inaction on the part of the licensee to ensure that residents are protected from abuse and neglect.The decision to issue this compliance order was based on the scope which was widespread, as well as the severity, which was potential for actual harm.

Non-compliance in the form of compliance orders were previously identified on

May 29, 2015 under inspection 32015_331595_0003 and November 30, 2015, under inspection #2015_264609_0053; and a voluntary plan of correction on March 21, 2016 were issued pursuant to LTCHA, 2007 S.O. 2007, c.8, 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.
(543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 03, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(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. 2007, c. 8, s. 23 (1).

Order / Ordre :

The licensee shall ensure that every alleged, suspected or witnessed incident of alleged abuse or neglect that the licensee knows of, or that is reported to the licensee, is immediately investigated.

Grounds / Motifs :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported were immediately investigated.

A critical incident related to alleged staff to resident sexual abuse that was reported to the Director. PSW #103 reported to the charge RN #108 that resident #001 reported that PSW #102 had allegedly touched them in an inappropriate manner.

Inspector #543 reviewed the home's written documentation (Interdisciplinary Progress notes) related to the incident which revealed that RN #108 did not interview resident #001 until the day after the incident. Further documentation provided by the Administrator confirmed that the initial investigation into the

alleged sexual abuse had not commenced until the day after the allegation. The Administrator did not follow up with the incident until approximately 10 days later.

During an interview with the Administrator, they confirmed that the investigation related to the incident that was reported had not commenced immediately. The Administrator confirmed that they had instructed the charge RN #108 to follow-up with the resident and the family. The Administrator also confirmed that they had not spoken with PSW #102, who was involved in the alleged staff to resident abuse until approximately 10 days later, stated they were on holidays.

The home's Zero Tolerance of Abuse and Neglect policy (NUM VII-7) policy noted that the most senior manager responsible or on duty or on call was responsible for ensuring all of the appropriate steps had been taken. Upon receiving notification of abuse allegations they would ensure an investigation and reporting process was underway by the staff person to whom the alleged abuse or neglect was reported. This policy also indicated that the home would immediately investigate allegations of abuse.

In an interview with RN #108, they stated that it was the home's expectation that all investigations related to abuse or alleged abuse that occurs in the home were initiated immediately.

In order to comply with the LTCHA 2007, s. 23, every licensee of a long-term care home shall ensure that, every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported to the licensee, are immediately investigated

The decision to issue this non-compliance order was based on the previous history of a written notification from inspection #2015_331595_0003 on May 29, 2015, although the scope was isolated, the severity identified a potential for actual harm. (543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 20, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 96. Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Order / Ordre :

The licensee shall ensure that their Zero Tolerance of Abuse and Neglect policy identifies and addresses all requirements with the with the Long-Term Care Homes Act, 2007 and Ontario Regulation 79/10.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's Zero Tolerance of Abuse and Neglect policy (NUM VII-7) of residents identified situations that may lead to abuse and neglect and how to avoid such situations.

The licensee has failed to ensure that the home's Zero Tolerance of Abuse and Neglect policy (NUM VII-7) of residents identified situations that may lead to abuse and neglect and how to avoid such situations.

Inspector #543 reviewed the home's Zero Tolerance of Abuse and Neglect policy (NUMVII-7) policy and identified that it did not address situations that may lead to abuse and neglect of residents and how to avoid such situations.

In an interview with the Administrator, the Inspector informed them that their abovementioned policy did not address such situations that may lead to abuse and neglect of residents and how to avoid such situations. The Administrator went through the policy and could not locate the same, and confirmed that their policy did not address any situations that may lead to abuse and neglect and how to avoid such situations.

Non-compliance was previously identified on May 29, 2015, under inspection # 2015_331595_0003. A compliance order was issued pursuant to O. Reg. 79/10, s. 96 (e) ii, every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, identifies the training and retraining requirements for all staff, including, situations that may lead to abuse and neglect and how to avoid such situations.

The decision to issue this compliance order was based on the previous history of non-compliance with an issued compliance order, the scope was widespread and the severity indicated a potential for actual harm.
(543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 03, 2016

Ontario

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

Ministére 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

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 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 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:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 5th day of May, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Tiffany Boucher

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