Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 3, 2020	2020_765541_0011	003233-20, 003811-20, 009338-20, 010307-20, 010927-20, 013446-20, 013741-20, 013749-20	Critical Incident System

Licensee/Titulaire de permis

Arch Long Term Care LP by its General Partner, Arch Long Term Care MGP, by its partners, Arch Long Term Care GP Inc. and Arch Capital Management Corporation
161 Bay Street Suite 2100 TORONTO ON M5J 2S1

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

Perth Community Care Centre
101 Christie Lake Road, R. R. #4 PERTH ON K7H 3C6

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

AMBER LAM (541), HEATH HEFFERNAN (622)

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): August 20, 21, 24, 25 & 26, 2020

The following logs were completed during this inspection:
Log #003811-20 CI #0962-000010-20 related to responsive behaviors and a resident fall
Log #009338-20 CI #0962-000015-20 related to a resident injury
Log #010307-20 CI #0962-000019-20 related to staff to resident abuse
Log #010927-20 CI #0962-000021-20 related to a fall with an injury
Log #013446-20 CI #0962-000023-20 related to fall with an injury
Log #013741-20 CI # 0962-000024-20 related to alleged resident neglect
Log #013749-20 CI #0962-000025-20 related to a fall with an injury
Log #003233-20 CI #0962-000007-20 related to responsive behaviors

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, a Clinical Manager, Registered Nurses, Personal Support Workers, a housekeeping staff and residents. In addition the inspector reviewed relevant policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any required policy put in place is complied with.

According to O. Reg 79/10 s. 48(1) every licensee shall ensure that the following interdisciplinary programs are developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

A resident sustained a fall. A PSW witnessed the fall and two RNs responded. An initial post-fall assessment was conducted by an RN who indicated that they did not suspect an injury based on the initial assessment. The RN and PSW both indicated to inspector that the resident was picked up off the floor by 3-4 staff members and a mechanical lift was not used. The RN indicated that a lift was not required. It was not until the resident was placed in a chair that the RN noted the resident's may have an injury.

The licensee's Zero Lift" policy which the home identified as part of their falls prevention and management program, indicates that "when a resident has fallen to the floor and when resident cannot assist, a mechanical lifting device must be used."

Two RNs and a PSW failed to comply with the licensee's Zero Lift policy when they assisted a resident who had fallen and sustained an injury off the floor without using a mechanical lift. [s. 8. (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 any required policy put in place is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #004 was protected from abuse.

According to O. Reg 79/10 s. 2(1) emotional abuse is defined as any threatening, insulting, intimidating or humiliating gestures, actions, behavior or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgment or infantilization that are performed by anyone other than a resident.

Two PSWs approached a resident to give them a bath. The resident was noted to be confused and slapped at staff. According to an interview with one PSW, while they went to assist the resident up by grabbing under their arm, the other PSW was on the other side of the resident and was described to roughly pick them up and swing them out of the chair. A housekeeping staff also witnessed the interaction and described the PSW as being rough with the resident. A PSW indicates following this interaction, the resident was upset and did not want to be around the PSW. The resident was asking for the PSW not to touch them. A PSW then described the other PSW as acting in a way that was emotionally abusive towards the resident. Following the bath, the resident was sitting at the front entry near where the housekeeping staff was sitting. The housekeeping staff member described the resident as being upset about their bath and would voice dislike of the PSW each time the staff member walked by.

The licensee failed to ensure that a resident was protected from abuse by a PSW in that they failed to:
- Follow their zero tolerance of resident abuse policy (see WN #3)
- Immediately report the incident to the Director (see WN #4)
- Immediately report the incident to the resident's SDM (see WN #5)
- Immediately report the incident to the Police (see WN #6) [s. 19. (1)]

2. The licensee failed to ensure that a resident was protected from neglect by a PSW.

According to O. Reg 79/10 s. 5 neglect is defined as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A resident sustained a fall. A PSW witnessed the fall and two RNs responded. The resident was transferred into a chair when an RN indicated noticing the resident appeared to have a possible injury. The RN gave direction to the PSW to stay with the resident while they went to call 911. When the paramedics arrived to transport the resident to the hospital for a possible injury, the resident was found to be in the bath. During an interview, the PSW indicated being in shock after witnessing the fall and did not hear the direction provided to them by the RN. The resident was taken for a bath while the RN was gone to call 911. A PSW who bathed the resident stated the resident did not demonstrate any signs of pain or discomfort while being bathed. The resident was then assisted to the stretcher by staff and paramedics and was transferred to the hospital where they were diagnosed with an injury.

The licensee failed to ensure that resident #001 was protected from neglect as:
- Staff did not follow the licensees zero lift policy when resident #001 was transferred off the floor and later into the bath without using a mechanical lift
- Resident #001 was taken into a bath immediately following a fall that resulted in an injury. [s. 19. (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 residents are protected from abuse and neglect by anyone, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure their policy titled “Zero tolerance to resident abuse and neglect” policy #02-01-02 was complied with, specifically the direction stating:

- Page 5/23 “A staff member who has allegedly abused a resident, family member, visitor, volunteer or other staff member should be sent home and replaced immediately.”

As noted in WN #2, a PSW was rough when assisting a resident up from a chair and when the resident asked not to be touched, the PSW was emotionally abusive towards the resident.

Both a PSW and a housekeeping staff reported the incident of alleged abuse to an RN. According to an interview with DOC, the PSW continued to work the remainder of the shift and was not put off work until the following day. [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 their policy titled "Zero tolerance to resident abuse and neglect" policy #02-01-02 is complied with, to be implemented voluntarily.

WN #4: 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 any of the following has occured, immediately report the suspicion and the information up which it was based to the Director: 2. Abuse of a resident by anyone.

As noted in WN #2, a PSW was rough when assisting a resident up from a chair and when the resident asked not to be touched, the PSW was emotionally abusive towards the resident.

The Director was not notified until a day later when the Critical Incident Report was submitted. [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 has reasonable grounds to suspect that any of the following has occured, immediately report the suspicion and the information up which it was based to the Director: 2. Abuse of a resident by anyone, 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 resident #004's substitute decision maker (SDM) was immediately notified upon becoming aware of the alleged incident of abuse.

As noted in WN #2, a PSW was rough when assisting a resident up from a chair and when the resident asked not to be touched, the PSW was emotionally abusive towards the resident.

According to an interview with the DOC, the resident's substitute decision-maker was not notified of the alleged abuse until the day following the incident. [s. 97. (1) (a)]

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 an alleged incident of abuse of resident #004 that the licensee suspects may constitute a criminal offense.

As noted in WN #2, a PSW was rough when assisting a resident up from a chair and when the resident asked not to be touched, the PSW was emotionally abusive towards the resident.

According to an interview with the DOC, the police were not notified until the day following the alleged abuse. [s. 98.]

Issued on this 15th day of September, 2020

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

Original report signed by the inspector.