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 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_772691_0007	009158-19, 009305-19, 010394-19	Critical Incident System

Licensee/Titulaire de permis

Victoria Village Inc.
76 Ross Street BARRIE ON L4N 1G3

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

Victoria Village Manor
78 Ross Street BARRIE ON L4N 1G3

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

JENNIFER NICHOLLS (691)

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): June 4-7, 2019.

The following intakes were inspected upon during the Critical Incident Inspection:
-Three logs, which were related to critical incidents the home submitted to the Director regarding incidents of resident to resident sexual abuse;

During the course of the inspection, the inspector(s) spoke with Chief Executive Officer (CEO), Director of Nursing (DON), Associate Director of Nursing (ADON), Behavioural Resource Manager, Community Service Worker with Behavioural Support Services (BSS), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

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

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified.

A Critical Incident System (CIS) report was submitted to the Director on an identified date, indicating that resident #001 was observed exhibiting a responsive behavior of a sexual nature towards resident #002 on two occasions.

Inspector #691 reviewed resident #001's health care record and identified a document dated the day that the incident occurred, which indicated that as of a result of the incident, resident #001 was to be provided with a specified intervention that was to be implemented for an identified period of time.

A review of the progress notes for resident #001, identified a note that was dated two days after the incident mentioned in the CIS report that indicated that during the period of time that the specified intervention was in place, resident #001 exhibited a responsive behavior of a sexual nature towards resident #006.

The Inspector reviewed the associated CIS report that was submitted to the Director for the incident that took place two days following the first incident.The report indicated that resident #001 was observed to be exhibiting a responsive behavior of a sexual nature towards resident #006.The CIS report further identified that while resident #001 was being redirected away, resident #001 exhibited another responsive behavior of a sexual nature towards resident #006.

A further review of resident #001 and resident #006's progress notes indicated that resident #001 should have continued to have the identified intervention in place at the

time of the second incident. It was further indicated that PSW #115 was responsible for providing the intervention, and they were from an external agency.

During separate interviews with PSW #107, #113, #104, RPN #112, and #108, they indicated that PSW #115 was from an external agency. It was indicated by interviewed staff, that PSW #115 was unaware of the specified instructions related to the identified intervention for resident #001, and was not effective at preventing resident #001's responsive behaviors.

During interviews with RPN #112, and #108, they indicated that as per the care plan, resident #001 required the identified intervention to protect other residents. RPN #112 indicated to the Inspector that the external agency PSW #115 was unclear of the specified instructions related to the identified intervention for resident #001 and did not provide care as specified in the plan of care.

In an interview with the Inspector, the Director of Nursing (DON) indicated that resident #001 had an identified intervention that was being provided by PSW #115 at the time of the incident. The DON further indicated to the Inspector that PSW #115 was not effective in providing the identified intervention. [s. 6. (7)]

2. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

A (CIS) report was submitted to the Director on identified date, indicating that resident #001 was observed to be exhibiting a responsive behavior of a sexual nature towards resident #006.

A) Inspector #691 reviewed resident #001 progress notes, which indicated that resident #001 had a specified type of assessment that was initiated on a identified date.

Inspector #691 reviewed the documentation for the specified assessment for resident #002 for a period of seven days. The Inspector identified missing documentation for the specified assessment on four occurrences during the specified period of time.

B) Inspector #691 reviewed a progress note at the end of the seven day period, which indicated that the specified type of assessment was to continue for an additional seven days. Inspector #691 reviewed the documentation of the specified type of assessment for a period of seven days and identified missing documentation on one occurrence

during the specified period of time.

C) Inspector #691 reviewed progress notes at the end of the second review period, which indicated that the specified type of assessment was to continue for an additional seven days for resident #001. Inspector #691 reviewed the documentation for the specified type of assessment for the period of seven days and identified missing documentation on four occurrences.

Inspector #691 reviewed policy titled "Responsive Behaviours" VII-F-30.00, last revised July 2017. The policy indicated that staff would recognize, report and document on a daily basis any resident with noted changes in behaviour.

D) Inspector #691 reviewed progress notes,which indicated that resident #006 had a specified type of assessment initiated on a identified date. Inspector #691 reviewed residents #006's documentation of the specified type of assessment for a period of seven days and identified missing documentation on three occurrences.

E) Inspector #691 reviewed progress notes seven days after the Inspector's second review period, which indicated that the documentation for the specified type of assessment for resident #006 was to continue for seven days. Inspector #691 reviewed the documentation for the specified type of assessment for a period of seven days and identified missing documentation on nine occurrences during the specified time period.

The Inspector reviewed the home's policy titled "Documentation-Resident Record", policy VII-K-10.00, last revised July 2017. The policy indicated that staff would participate in documenting on the assigned tools and used by all members of the interdisciplinary team. The policy indicated that a PSW, would record all pertinent resident care delivery information prior to the end of their shift on the resident's individual record.

The Inspector interviewed PSW #107, who indicated that residents who required the specified type of assessment had documentation completed for an identified period of time, and further indicated that there was missing documentation. PSW #107 further indicated that the specified type of assessment was kept in the PSW binder at the nursing station and discussed at shift report.

Inspector #691 interviewed RPN #112, who indicated that any staff member, including PSWs could document on the specified type of assessment and that the expectation was that it had to be completed for the entire 24 hour period.

Inspector #691 interviewed PSW #107, and RPN #112, who reviewed the documentation for the specified type of assessments for resident #001 and #006 and confirmed that there was missing documentation, which indicated that staff did not complete documentation as required.

Inspector #691 interviewed the DON, who verified that all staff were trained on documentation and could document on the specified type of assessment. The DON confirmed that it was the expectation that any staff member that worked on the unit, implement the specified type of assessment and document as indicated.The DON confirmed the expectation was that, when a resident required this specified this type of assessment, that the documentation would be completed. The DON acknowledged that the documentation for the specified type of assessment for resident #001 and resident #006 was not completed as required. [s. 6. (9) 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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that any report to the Director included a description

of the individuals involved in the incident, including, i. names of any residents involved in the incident.

1. A CIS report was submitted to the Director on an identified date, for an allegation of abuse of a resident by the licensee or staff that resulted in harm or risk of harm to the resident. The CIS report identified that on an identified date, resident #001 was observed exhibiting a responsive behavior of a sexual nature to a resident whom was not identified in the CIS report.

Inspector #691 reviewed documentation, from the call made from the home to the after-hours line regarding the incident involving resident #001.The after-hours call indicated that resident #001 was exhibiting responsive behavior of a sexual nature towards resident #004. After review of resident #004 progress notes, Inspector #691 could not locate any documentation related to this specific incident on the specified date.

On a identified date, four days after the incident, the Director requested an amendment to the CIS report to include the resident's name involved in the incident, residents past behaviours, diagnosis, current status of residents, results of the investigation and actions taken to prevent a recurrence. The amendment was requested to be completed by a specified date.

The Inspector reviewed the critical incident reports submitted to the Director from the licensee and located an amended CIS report dated nine days after requested date, that indicated the resident's past behaviors and current status of the resident and actions taken to prevent recurrence. The Inspector was unable to locate any amended CIS reports related to resident #006, that indicated that they were the resident involved in incident.

During interviews with RPN #108 and PSW #107 they identified to the Inspector that the incident with resident #001, which occurred on a specified date, was involving resident #006, not resident #004. Inspector #691 reviewed resident #006's progress notes which identified resident #001 was exhibiting a responsive behavior of a sexual nature towards resident #006.

A review of the policy titled "MOHLTC- Critical Incident Reporting", policy I-F-48.00, last revised May 2018, indicated that the Director of Nursing (DON) was responsible to ensure that all required documentation was completed in the Critical Incident System portal as per the MOHLTC standards.

In an interview with Inspector #691, the DON indicated that a CIS report was to include the names of residents who were involved in the incident. The DON further indicated that they were responsible to submit and update the CIS report within the home.

Together, the Inspector and the DON reviewed the CIS report, which included the information requested by the Director and amendments to the report. The DON indicated that they had called the after-hours reporting line on the specified date, with the wrong resident information. The DON further indicated that they did not include the resident's name when submitting the CIS report two days after the incident, and did not complete the amendment indicating the correct name of the resident involved as requested by the Director. [s. 107. (4)]

Issued on this 14th day of June, 2019

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

Original report signed by the inspector.