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 soins 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
Jun 30, 2016	2016_396103_0021	013546-16, 013561-16, 017810-16	Critical Incident System

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

WEST LAKE TERRACE
1673 COUNTY ROAD, 12 R. R. #1 PICTON ON K0K 2T0

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

DARLENE MURPHY (103)

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 21, 22, 24 and 28, 2016

The following logs were included in this inspection: 013546-16 (alleged staff to resident abuse), 013561-16 (alleged staff to resident abuse) and 017810-16 (alleged staff to resident abuse).

During the course of the inspection, the inspector(s) spoke with residents, Personal support workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Housekeeping staff, Life Enrichment Coordinator, the Director of Care and the Administrator.

During the course of the inspection, the inspector reviewed resident health care records, the home's abuse policy and the home's education records related to abuse training.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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	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. 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 findings relate to Log #013546-16 and #017810-16:

The licensee has failed to ensure that care set out in the plan of care for resident #001

and #003 was provided as specified in the plan.

On an identified date, resident #001 was overheard yelling in the dining room. RN #108 observed PSW #107 acting inappropriately with the resident. The RN interviewed the PSW at the time of the incident who indicated it was done only as a joke.

Resident #001's care plan was reviewed. The plan indicated the resident had identified diagnoses which resulted in identified behaviours. The plan indicated:

- staff should be cautious in what they say and to maintain a consistent and firm routine and approach in relation to care,
-avoid positive reinforcement of negative behaviours, and
-avoid conversations that may encourage or initiate inappropriate behaviour.

In a discussion with the Administrator, he indicated the staff member was reprimanded for what he determined to be a demonstration of power imbalance between the staff member and the resident. PSW#107 failed to provide care to resident #001 as outlined in the resident's plan of care. [s. 6. (7)]

2. Resident #003's health care record was reviewed and indicated the resident had identified diagnoses. During a review of the resident health care record, it was noted the resident had been sleeping in and frequently missing meals. The progress notes indicated on five identified dates, the resident was upset with staff for attempting to cue the resident to go to bed at night and get up in the morning. The resident was noted to respond negatively to the approaches used.

PSW staff were interviewed in regards to the strategies being used with this resident when they sleep in. The staff stated they are often pressured by registered staff to awaken the resident to persuade them to attend meals or to get up and dressed. Staff report resident #003 becomes upset and has attempted to strike out at staff when they try to insist they attend meals. PSW #104 indicated on one particular day the resident had an identified appointment scheduled at 1000 hour and the PSW was told by the registered staff that the resident must be gotten up for this appointment. The staff member indicated resident #003 cannot be rushed and has their own routine and indicated she believes the resident has the right to sleep in.

Resident #003's care plan was reviewed. Under "eating" the care plan indicated:
- the resident is methodical and slow in completing tasks,

-the resident attends the dining room for meals however at their own pace.

Under "Decision-making" the care plan indicated:
- the resident functions at a high level and remains determined to continue with independence in performing personal care/tasks/activities in accordance with set rituals,
-Staff should provide non-intrusive prompting and encouragement while recognizing the resident's need to pace themself.

Resident #003's sleep patterns and preferences were not identified in the plan of care.

The DOC was interviewed and asked what her expectations would be when a resident wishes to sleep in. The DOC stated she would expect the resident's right to sleep in would be respected, but also indicated the resident's routine of rummaging was disruptive especially at night. The care plan did include rummaging as a behaviour, but there was no indication this had been reported or identified as disruptive. The DOC indicated specific strategies were required to be included in the resident care plan to support and respect the resident's care needs. [s. 6. (7)]

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 care outlined in resident #001 and #003's plan of care are provided in accordance with the plan. In addition, resident #003's care plan should be updated to accurately reflect the resident's sleep preferences and measures to support the resident's right to refuse, to be implemented voluntarily.

WN #2: 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).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The following findings relate to Log #013546-16, #013561-16 and #017810-16:

The licensee has failed to ensure the home's zero tolerance of abuse policy was complied with.

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

As outlined in WN #1, an incident involving resident #001 occurred. RN #108 failed to

immediately report this alleged incident of abuse. On an identified date, the RN submitted a written statement to the Administrator indicating, at the time of the alleged incident, she wasn't sure if a report was required, but now realized it should have been immediately reported. Upon becoming aware of the incident, the home contacted the police and the resident's substitute decision maker (SDM) and began an investigation into the incident.

The home's Zero tolerance of abuse policy was reviewed. Policy# AM-6.7 under "Procedure" indicated: upon becoming aware of any of the following, alleged, suspected or witnessed incidents of resident abuse, the home shall contact the Ministry of Health immediately. The MOHLTC was notified for the first time of this alleged abuse when the home submitted a critical incident on an identified date.

In addition, the home failed to report to the Director (MOHLTC) the results of the abuse investigation. The home's abuse policy# AM 6.7 indicated under "Responsibility": it is the responsibility of the Administrator or designate to ensure a thorough investigation of the incident is conducted and submitted to the Ministry of Health within the required timelines. [s. 20. (1)]

2. On an identified date, RN #106 was advised by PSW #107 that resident #002 had been upset and yelling on the previous evening. The PSW indicated when she asked the resident what was wrong, the resident reported being upset because he had been struck on the head with a pencil by a staff member. The RN was interviewed and indicated the PSW had not advised anyone of this allegation on the date it allegedly occurred. RN #106 stated he spoke with the resident at that time and the resident relayed the same story to him. The RN stated he got busy and did not report this alleged abuse to anyone until the following day when he reported it to the Administrator.

The Administrator was interviewed and indicated after being made aware of the alleged incident, he notified the police on an identified date The Administrator indicated the resident had no SDM. The MOHLTC was not notified of the alleged abuse until two days later at which time a critical incident was submitted. The Administrator indicated upon completion of the investigation, the home determined there were no findings, however the home failed to ensure the results of the investigation into the alleged abuse was reported to the Director (MOHLTC).

As outlined above, the home failed to follow their abuse policy by immediately reporting the alleged abuse to the MOHLTC. PSW #107, who became aware of the incident on an

identified date, failed to report it to the RN in charge. The following day, RN #106 failed to report the alleged incident to the MOHLTC and the Administrator failed to report the alleged incident to the MOHLTC until two days after being made aware of the alleged incident. In addition, the home failed to report the outcome of the investigation into the alleged abuse to the MOHLTC. [s. 20. (1)]

3. On an identified date, resident #003 was observed being walked down the hallway toward the dining room with PSW #102. The resident was observed by staff member #103 to be very upset and crying. Staff member #103 was interviewed and indicated she had never seen the resident this upset before and described the resident as crying so hard that she could not understand what the resident was trying to say. The staff member stated she consoled the resident who was finally able to state that two staff had pushed him/her out of the room and his/her elbow had hit the door. Staff member #103 indicated she did not report this to anyone that day, however she did confide in another staff member the following day who immediately reported it to the Director of Care. Staff member #103 indicated she was unsure if she should report the incident but stated she would not hesitate in the future to do so.

The home, upon becoming aware of the incident, did immediately notify the MOHLTC, the police and the SDM of the alleged incident. However, upon completion of the investigation, the home failed to update the Director (MOHLTC) with the outcome of the investigation.

As outlined above, the home failed to follow their abuse policy by immediately reporting an alleged resident abuse to the MOHLTC and informing the Director of the outcome of the investigation into the allegation of abuse. [s. 20. (1)]

4. The licensee has failed to ensure that the home's abuse policy complies with the legislated requirements.

In reference to the above incident involving resident #002, the Administrator was asked what actions the home took, after being made aware of the alleged abuse, to immediately investigate the allegations involving resident #002. He indicated the home determined the risk and severity of the incident did not warrant the relief of the accused staff member from their duties and therefore the staff member could continue working. The Administrator indicated he spoke with the resident for the first time two days after being made aware of the alleged incident, but was unable to explain the delay.

LTCHA, 2007, s. 23 (1) (a) states, 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.

The Administrator was asked to provide this inspector with a copy of the home's abuse policy. The inspector was provided with "Whistleblowing Protection", #AM-6.2, "Investigation Procedures", #AM-6.3, "Reporting Incidents of Abuse, #AM-6.7, and "Zero tolerance of abuse", #AM-6.9.

The above were reviewed and all portions of the abuse policy provided make reference to conducting an investigation but fail to include the above requirements to immediately investigate all alleged, suspected, or witnessed incidents of resident abuse or neglect. [s. 20. (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 all staff report all suspected, alleged or witnessed incidents of resident abuse and neglect in accordance with the home's abuse policy, ensure the results of every investigation into resident abuse and neglect are reported to the Director and to ensure the home's abuse policy accurately reflects the legislated requirement to immediately investigate all suspected, alleged or witnessed incidents of resident abuse and neglect, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
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. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all 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. 104 (1).

Findings/Faits saillants :

1. The following findings relate to Log #017810-16:

The licensee has failed to ensure a report submitted to the Director included the date and time of the incident.

On an identified date, the home submitted a critical incident (CIS) to report an alleged staff to resident abuse involving resident #003. The CIS indicated an identifed date of the incident. The Director of Care was interviewed in regards to the investigation into the incident and advised the incident actually occurred on the previous date and not the date indicated on the CIS [s. 104. (1) 1.]

2. The licensee has failed to ensure that names of all staff members alleged to be involved in a staff to resident abuse were included in the critical incident submitted to the MOHLTC.

As outlined in WN #2, this inspector interviewed the DOC to determine the home's actions into the alleged staff to resident abuse involving resident #003. During the interview, this inspector was informed of the names of the two PSW staff that were alleged to have been involved in this incident. The CIS did not include these staff names. [s. 104. (1) 2.]

Issued on this 6th day of July, 2016

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

Original report signed by the inspector.