Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Nov 7, 2019	2019_684604_0024	026122-18, 006666-19	Critical Incident System

Licensee/Titulaire de permis

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

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

The Willows Estate Nursing Home
13837 Yonge Street AURORA ON L4G 3G8

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

SHIHANA RUMZI (604)

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): October 21, 22, 23, 24, 28, and 29, 2019.

During this inspection the following intakes were inspected:
-Intake log #026122-18, related to related to alleged abuse

-Intake log #006666-19, related to related to an incident and transfer to hospital

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with the Administrator, Previous Director of Care (PDOC), Charge Registered Nurses (CRN), Registered Nurse (RN), Registered Practical Nurses (RPN), Minimum Data Set Coordinator (MDSC), Personal Support Workers (PSW), Nursing Administrative Services Manager (NASM), Falls Program Lead (FPL), Physiotherapist (PT), and Physiotherapist Assistant.

During the course of the inspection, the inspectors conducted observations of staff and resident interactions, provision of care, reviewed home's CIS report investigation binder, conducted reviews of health records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **7 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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the licensee fully respected and promoted the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respected their dignity.

On an identified date, the home submitted Critical Incident System (CIS) report to the Ministry of Long-Term Care (MLTC) Director which indicated abuse had occurred. The CIS report further stated a Registered Nurse (RN) alleged Personal Support Worker (PSW) abused resident #002 during care.

A review of the resident's plan of care consisted of a focus and interventions giving staff direction related to resident's care needs.

In an interview Charge Registered Nurse (CRN) #102 stated they worked on an identified date and home area. The CRN indicated they were in an identified area of the home and heard yelling coming out of an identified area and heard PSW #101 speaking inappropriately with resident #002. The CRN indicated PSW #101 was speaking inappropriately to resident #002.

In a further interview with CRN #102 indicated they began medication pass and went into to an identified area of the home after the above incident had occurred. The CRN indicated they observed resident #002 put their arms up in the air and yell "Stop" and observed PSW #101 abuse the resident. The CRN stated they provided resident #004 nursing care as PSW #101 completed identified care for resident #002. The CRN stated once the PSW left the identified area the CRN called the manager on-call. CRN #102 stated they did not immediately remove PSW #101 at the time they heard PSW #101 speak to at resident #002 inappropriately and acknowledged they witnessed PSW #101 abuse resident #002, waited till the care was completed and waited till the PSW left the identified area. The CRN stated resident #002 was not treated with courtesy and PSW

#101 did not respect the resident.

In an interview with PSW #101 they acknowledged they worked on an identified date and area of the home, and provided care to resident #002. The PSW indicated resident #002 presented with identified responsive behaviors and on an identified date resident #002 was presenting with responsive behaviors during care and attempts to strike the PSW. The PSW stated they where stern with their voice when providing care on an identified date and stated did not identify their stern voice as not being courteous and disrespectful to resident #002.

In an interview with Administrator #103 indicated they were aware of the above two incidences involving PSW #101 and resident #002. The Administrator further acknowledged PSW #101 was not acting courteously and respectfully to resident #002.

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 licensee fully respected and promoted the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

The licensee has failed to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and was present at all times.

According to O. Reg. 79/10, s. 6, "regular nursing staff" means a member of the registered nursing staff who works in a long-term care home at fixed or prearranged intervals.

On an identified date, the home submitted a CIS report to the MLTC Director indicating resident #001 sustained an injury and the resident was transferred to hospital. The CIS report stated the Registered Practical Nurse (RPN) #113 found resident #001's in an identified area of the home and had an identified incident.

The resident was assessed and found to have an injury and the resident was transferred to hospital for further assessment. The CIS report further stated the resident was admitted to hospital with identified diagnosis.

A review of resident #001's e-notes reveled the agency RN #113 had documented the incident which had occurred on an identified date and shift and the RPN on duty was also from agency.

Inspector #604 reviewed January, February, March, August, and September 2019, registered staff schedules and noted agency RN and RPN staff where utilized on an identified shift on multiple identified date.

An interview with the previous Director of Care (DOC) #109 who acknowledged on identified dates the home did not have a registered nurse who was an employee of the home and agency staff where utilized.

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 at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and was present at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licenses has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

On an identified date, the home submitted Critical Incident System (CIS) report to the Ministry of Long-Term Care (MLTC) Director which indicated abuse had occurred. The CIS report further stated a Registered Nurse (RN) alleged Personal Support Worker (PSW) was inappropriately to resident #002 during care.

A review of the resident's plan of care consisted of a focus and interventions giving staff direction related to resident's care needs.

In an interview with PSW #101 they acknowledged they worked on an identified date and shift and provided care to resident #002. The PSW stated resident #002 was in an identified area of the home and required care with an identified number of staff. The PSW stated they carried out the identified care on their own without a second staff members assistance.

In an interview Administrator #103 stated they carried out the investigation for the above CIS report related to abuse. The Administrator indicated during the interview PSW #101 was asked to describe how they provided an identified care to resident #002 at which time PSW #101 indicated they performed an identified care for resident #002 by themselves. The Administrator stated PSW #101 put resident #002 in danger as they did not have a second staff member to assist in providing the identified care.

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 staff used safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: 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. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

The licensee has failed to ensure that when an incident had occurred which caused an injury to the resident for which the resident was taken to a hospital, the licensee determines that the injury had resulted in a significant change in the resident's health condition and the Director was informed of the incident no later than three business days after the occurrence of the incident.

On an identified date, the home submitted a CIS report to the MLTC Director indicating resident #001 had an identified incident and the resident was transferred to hospital. The CIS report stated Registered Practical Nurse (RPN) found resident #001's in an identified location of the home and assessed the resident and noted an identified injury and the resident was transferred to hospital for further assessment. The CIS report further stated the resident was admitted to the hospital and with an identified injury.

A review of resident #001's e-notes was carried out for an identified period for an identified incident.

Further review of resident #001's e-notes revealed documentation by a physician indicating identified injuries.

An interview was carried out with the home's Previous Director of Care (PDOC) #109 who reviewed the above CIS report and e-notes related to resident #001's identified incident and hospital transfer for an identified date. The DOC acknowledged resident #001 did have an identified incident, and home was aware of resident #001's injuries once updated by the hospital which had resulted in a significant change in the resident's health condition. The PDOC further acknowledged the CIS report was not submitted within three days and was submitted nine days later.

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 when an incident has occurred which caused an injury to the resident for which the resident was taken to a hospital, the licensee determines that the injury has resulted in a significant change in the resident's health condition and the Director was informed of the incident no later than three business days after the occurrence of the incident, to be implemented voluntarily.

WN #5: 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 :

The licensee has failed to ensure that there was a written policy that promotes zero tolerance of abuse of residents and that it was complied with.

On an identified date, the home submitted Critical Incident System (CIS) report to the Ministry of Long-Term Care (MLTC) Director which indicated abuse had occurred. The CIS report further stated a Registered Nurse (RN) alleged Personal Support Worker (PSW) speaking inappropriately to resident #002 during care.

A review of the home's policy titled "Abuse/Neglect of Residents by Staff", #HR-RA-2.2, with an effective date as August 2011, indicates the employee alleged to have committed the abusive or neglectful act will immediately be removed from the work environment pending investigation.

An interview was carried out with CRN #102 who stated when staff witness or hear of abuse, staff are to intervene, ensure the resident was safe, and remove the staff or resident immediately from the area of the abuse. The CRN further stated they are to contact the manager on-call for further direction. The CRN indicated they worked on an identified shift and home area on an identified date. The CRN stated they were in an identified area of the home and heard yelling in an identified area of the home and heard PSW #101 speak to resident #002 inappropriately. The CRN stated they informed PSW #101 they where speaking inappropriately to resident #002. The CRN stated PSW #101 was abusive towards resident #002 during care. The CRN further acknowledged they should have removed PSW #101 when the abuse occurred and should have called the manager on-call.

In separates interviews with PDOC #109 and Administrator #103, stated when staff witness or hear of staff to resident abuse, they are to intervene, ensure the resident was safe, remove the staff or resident immediately from the area, and call the manager on-call for further direction. The PDOC and Administrator indicated CRN #102 did not follow the home's policy as the CRN #102 did not remove PSW #101 when they initially heard the PSW abuse resident #002 by yelling at the resident. The PDOC and Administrator acknowledged CRN #102 removed PSW #101 after the second incident of abuse had occurred involving resident #002, and not waited until the PSW completed their care, and left an identified area of the home.

WN #6: 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. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the results of the abuse investigation was reported to the Director.

On an identified date the home submitted a CIS report to the MLTC Director which indicated abuse had occurred. The CIS report further stated RN staff alleged PSW spoke inappropriately to resident #002 and abused the resident during care.

Inspector #604 reviewed the home's investigation file related to the above CIS report and noted CIS report was not amended to include the home's investigation.
An interview was carried out with Administrator #103 who acknowledged the CIS report was not amended to informed the MLTC Director of results of the abuse investigation.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions including risk of falls.

On an identified date, the home submitted a CIS report to the MLTC Director indicating resident #001 had an identified incident and the resident was transferred to hospital. The CIS report stated Registered Practical Nurse (RPN) found resident #001's in an identified location of the home and assessed the resident and noted an identified injury and the resident was transferred to hospital for further assessment. The CIS report further stated the resident was admitted to the hospital and with an identified injury.
A review of resident #001's e-note was carried out for an identified period and on an identified date the Physiotherapist (PT) e-note had documented their assessment of the resident.

Review of resident #001's e-Assessments was carried out and an identified assessment indicated resident #001's previous history related to an identified incident along with risk. Subsequent assessments also indicated resident #001 incident risk had not changed.

A review of resident #001's plan of care for an identified period did not consisted of an identified problem statement and interventions related to identified incidents.

In separate interviews with RPN #105 and PDOC #109 indicated the plan of care was to be reviewed and new interventions put in place after each identified incident. The RPN and PDOC indicated resident #001 was at risk for an identified incident from their past history. The RPN and DOC reviewed residents #001's plan of care and acknowledged the plan of care was not updated to show interventions.

Issued on this 14th day of November, 2019

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

Original report signed by the inspector.