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**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 14, 2015 | 2015_293554_0018 | O-002464-15 | Critical Incident System |

### Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

WINBOURNE PARK
1020 Westney Road North AJAX ON L1T 4K6

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

KELLY BURNS (554)

### 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 5-7, 2015 (onsite)**

**Critical Incident - Intake #O-002464-15**

**This Critical Incident Report(CIR) was submitted by the home; the CIR is specific to an incident of alleged staff to resident abuse (and relates to Resident #001).**

**During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Recreation Aide, RAI-Coordinator, and Education Coordinator.**

**During the course of this inspection, the inspector reviewed: clinical health records for**
**deceased resident (Resident #002), staff education specific to zero tolerance of abuse, reviewed home policies, including Resident Non-Abuse, Pain Assessment and Symptom Management.**

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

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**Findings/Faits saillants :**

1. The licensee failed to comply with LTCHA, 2007, s. 6 (1) (c), by not ensuring there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident, specifically as such relates to pain and comfort.

Resident #001 has a diagnosis that includes chronic discomfort.

The Administrator, submitted a Critical Incident Report on a specific date, for an alleged incident of staff to resident physical abuse; during this alleged incident Resident #001 indicated Personal Support Worker #006 pulled his/her upper extremity during care, which caused resident discomfort.

During an interview, with the inspector, Director of Care (DOC) indicated that Resident #001 has a chronic condition of a specific extremity, which limits mobility of the extremity and causes resident discomfort. DOC indicated that all direct care staff are aware that Resident #001's extremity is chronically uncomfortable and that staff should have known to take special care with resident when providing care and or dressing Resident #001.

Registered nursing staff and personal support workers, interviewed, all indicated knowing that Resident #001 had chronic discomfort to specific body; all staff interviewed indicated having no knowledge of Resident #001 having discomfort to a specific extremity and could not provide specific interventions, in relation to providing care and or dressing specific to the extremity being uncomfortable or having limited mobility.

The written plan of care, last revised on a specific date indicates, Resident #001 has alteration in comfort, chronic discomfort. Interventions listed include, staff to encourage mobility; see medication record for routine and as needed medications; administer specific medications prior to attendance at chosen activities; and notify doctor of any new or changes in resident's comfort level.

Director of Care indicated that the written plan of care should have included specific interventions relating to providing care and or dressing noting Resident #001's chronic discomfort and limited mobility of this same extremity.

***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 there is a process in place and monitored, ensuring there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident, specifically as such relates to pain and comfort, to be implemented voluntarily.***

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**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 failed to comply with LTCHA, 2007, s. 23 (1) (b), by not ensuring that appropriate action is taken in response to every such incident of alleged physical abuse.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" is defined as (a) the use of physical force by anyone other than a resident that causes physical injury or pain; and (c) the use of physical force by a resident that causes physical injury to another resident.

The Administrator submitted a Critical Incident Report to the Director on a specific date,

related to an alleged incident of staff to resident physical abuse; the alleged incident was said to have occurred on a specific date and at a specific time.

Details of the Critical Incident Report are as follows:
- Resident #001 reported to a Recreation Aide #005 that he/she was afraid of Personal Support Worker (PSW) #006. Recreation Aide #005 indicated that Resident #001 was visibly upset and crying while disclosing information as to the alleged physical abuse incidents. Resident #001 indicated (to Recreation Aide) that PSW #006 is "rough with him/her during care, and pulls on a specific extremity during care, despite knowing the extremity is uncomfortable". Resident indicated, to Recreation Aide, being terrified each time PSW #006 enters his/her room; resident indicated (to recreation aide) he/she is so afraid of PSW #006, that he/she avoids calling to use the toilet and will count down the hours until the next shift arrives.

Recreation Aide #005 reported the alleged physical abuse allegation to the Executive Director following Resident #001's disclosure. According to the CIR, Executive Director interviewed Resident #001 on the same date and found resident visibly upset, and fearful of being alone.

Resident #001 reiterated the same details of the abuse incident to the Executive Director, indicating his/her extremity is sore.

A review of the witness statements, provided to the inspector by the Director of Care, and the progress notes (specific dates), interview with Registered Nurse #020 and Director of Care all indicated no physical assessment was conducted, of Resident #001, until the next day, despite resident complaining of discomfort to the extremity and being tearful.

Registered Nurse #020, who was the assigned charge nurse on the shift, date of the incident indicated he/she was not informed by the Executive Director of any alleged physical abuse incident nor was he/she directed to physically assess Resident #001; RN #020 indicated he/she was directed by the Executive Director to monitor Resident #001's mood during the specific shift.

The home's policy, Resident Non-Abuse (#LP-C-20-ON) directs that immediate interventions following allegations of resident abuse is to, ensure the safety and comfort of the abuse victim (resident), first taking all reasonable steps to provide for resident's immediate safety and well-being, then through completion of full assessments, a determination of the resident's needs and a documented plan to meet those needs. The

policy further directs, that in cases of physical abuse, staff are to obtain consent to take pictures of any injuries and accurately detail a description of injuries and condition and document such in resident's chart.

Director of Care indicated that being first informed of the alleged incident of physical abuse towards Resident #001 the next day, and at an approximate time. Director of Care indicated being the first registered nurse (or registered nursing staff) to assess Resident #001 and any such related injuries. As per Director of Care, resident had no visible injuries, but was complaining of discomfort to an extremity, which prompted him/her to contact the Nurse Practitioner to further assess Resident #001.

Director of Care was in agreement, that according to progress notes, no assessment of Resident #001 occurred until approximately fourteen hours, following resident's disclosure of the staff to resident physical abuse allegation.

Director of Care indicated it would be an expectation that any resident alleging abuse, especially physical abuse, would have been assessed immediately.

***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 there is a process in place and monitored, ensuring that appropriate action is taken in response to every such incident of alleged, suspected or witnessed abuse, to be implemented voluntarily.***

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**WN #3: 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 failed to comply with LTCHA, 2007, s. 24 (1), by not ensuring the person who had
reasonable grounds to suspect that any of the following has occurred or may occur, immediately
report the suspicion and the information upon which it was based to the Director, specifically,

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Under O. Reg. 79/10, s. 107 (2), where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after-hours emergency contact.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" is defined as (a) the use of physical force by anyone other than a resident that causes physical injury or pain; and (c) the use of physical force by a resident that causes physical injury to another resident.

The Administrator submitted a Critical Incident Report to the Director on a specific date and at a specific time, related to an alleged incident of staff to resident physical abuse,

which occurred the same day at an approximate time.

Details of the Critical Incident Report are as follows:
- Resident #001 reported to a Recreation Aide #005 that he/she was afraid of Personal Support Worker (PSW) #006. Recreation Aide #05 indicated that Resident #001 was visibly upset and crying while disclosing information as to the alleged physical abuse incidents. Resident #001 indicated, to the recreation aide, that PSW #006 is "rough with him/her during care, and pulls on his/her extremity during care, despite knowing the extremity is uncomfortable. Resident indicated, to recreation aide, being terrified each time PSW #006 enters his/her room; resident indicated he/she is so afraid of PSW #006, that he/she avoids calling to use the toilet and will count down the hours until the shift arrives.

A representative from the Centralized Intake Assessment Team (C.I.A.T.T) and Spills Action Centre (SAC), both, indicated that the LTC home did not contact them via the MOHLTC after-hours contact number (phone number) of the alleged incident of staff to resident physical abuse.

The Director of Care indicated the home's management team and registered nursing staff have access to the MOHLTC after-hours contact number and are aware that alleged, suspected or witnessed abuse is to be immediately reported to the Director.

Note:
Long-Term Care Homes and their Licensees have been provided ongoing communications from the Ministry of Health and Long-Term Care pertaining to the reporting requirements for both mandatory and critical incidents, according to the communication, the following is required, specifically as it relates to Abuse.

Abuse of a resident by anyone, is to be immediately reported by initiating the online MCIS form using the mandatory report section (between the hours of 08:00-17:00 hours, Monday to Friday; all other times, the notification is to be made via the after-hours phone, followed by the completion of the report within 10 days, or unless otherwise indicated.

***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 there is a process in place and monitored, ensuring the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, specifically, as it relates to abuse of a resident by anyone, to be implemented voluntarily.***

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**WN #4: 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. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).**

**Findings/Faits saillants :**

1. The licensee failed to comply with O. Reg. 79/10, s. 97 (2), by not ensuring that the resident and resident's substitute decision maker (SDM) were notified of the results of the alleged abuse (or neglect) investigation immediately upon the completion.

The Administrator submitted a Critical Incident Report to the Director on a specific date, related to an alleged incident of staff to resident physical abuse.

Details of the Critical Incident Report are as follows:
- Resident #001 reported to a Recreation Aide #005 that he/she was afraid of Personal Support Worker(PSW) #006. Recreation Aide #005 indicated that Resident #001 was visibly upset and crying while disclosing information as to the alleged physical abuse incidents. Resident #001 indicated, to recreation aide, that PSW #006 is "rough with him/her during care, and pulls on a specific extremity during care, despite knowing the extremity is uncomfortable. Resident indicated, to recreation aide, being terrified each time PSW #006 enters his/her room; resident indicated he/she is so afraid of PSW #006, that he/she avoids calling to use the toilet and will count down the hours until the next shift arrives.

Witness statements, provided to the inspector by the Director of Care, indicated that the alleged staff to resident physical abuse incident was reported to the Executive Director, by Recreation Aide #005 on a specific date. Executive Director interviewed Resident #001 that same date and found resident visibly upset and fearful of being alone; Resident #001 reiterated the same details as disclosed to Recreation Aide #005.

The home's investigation began, on a specific date, with PSW #006 and other staff who may have had knowledge of the alleged physical abuse incident. As per the home's investigational notes, (written by Director of Care and Executive Director) the investigation into the physical abuse allegation concluded approximately one week later.

Director of Care indicated the investigation was inconclusive; DOC further indicated PSW #006 was to be cognizant of how he/she communicates with residents during care and was no longer to provide direct care to Resident #001.

Director of Care indicated that neither Resident #001 nor resident's substitute decision maker were notified of the outcome of the home's investigation.

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**Issued on this 10th day of November, 2015**

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

**Original report signed by the inspector.**