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

Ottawa Service Area Office
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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
May 21, 2019	2019_785732_0006 (A1)	003156-18, 006165-18, 008739-18, 010589-18, 011041-18, 017976-18, 019196-18, 026655-18, 029305-18, 032311-18, 002567-19, 003526-19, 005536-19	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the County of Renfrew
9 International Drive PEMBROKE ON K8A 6W5

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

Miramichi Lodge
725 Pembroke Street West PEMBROKE ON K8A 8S6

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

Amended by EMILY BROOKS (732) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Inspector #732 received a revised Clinical Practice Guideline: Falls Risk Reduction Program from the Licensee on May 21, 2019. Upon review, previous WN and CO no longer applicable. WN revoked and CO rescinded.

Issued on this 21st day of May, 2019 (A1)

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

Original report signed by the inspector.

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

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

Amended by EMILY BROOKS (732) - (A1)

Amended 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): March 5-8, 2019, March 11-15, 2019, and March 18-20, 2019 onsite; March 21 and 22, 2019 offsite

The following intakes were completed during this Critical Incident System inspection:

Log #003156-18 (CIS #M621-000003-18), Log #006165-18 (CIS #M621-000006-18), and Log #032311-18 (CIS #M621-000034-18) related to prevention of abuse and neglect.

Log #019196-18 (CIS #M621-000024-18), Log #017976-18 (CIS #M621-000023-18), Log #026655-18 (CIS #M621-000030-18), Log #003526-19 (CIS #M62-000005-19),

Log #002567-19 (CIS #M62-000004-19), Log #011041-18 (CIS #M621-000013-18), Log #008739-18 (CIS #M621-000010-18), Log #010589-18 (CIS #M621-000012-18), and

Log #029305-18 (CIS #M621-000033-18) related to falls prevention and management.

Log #005536-19 (CIS #M621-00009-19) related to an unexpected death.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Resident Care Coordinators (RCC),

Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents, and resident family members.

In addition, the inspectors reviewed critical incident reports, health care records, licensee internal investigation documentation as applicable, and policies related to the prevention of abuse and neglect, whistle blower protection, and the falls prevention program. The inspectors observed resident care environments, including bedrooms, and staff to resident interactions.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of the original inspection, Non-Compliances were issued.

- **5 WN(s)**
- **0 VPC(s)**
- **2 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 #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 resident #006 was protected from abuse by the licensee or staff in the home.

In accordance with O.Reg. 79/10, section 2, verbal abuse means, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's

sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

In accordance with O.Reg. 79/10, section 2, physical abuse means, the use of physical force by anyone other than a resident that causes physical injury or pain.

On a specific date, The Ministry of Health and Long-Term Care (MOHLTC) Info line – LTC after hours was contacted by the licensee to report an incident of alleged staff to resident verbal and physical abuse.

The next day, a Critical Incident Report (CIR) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to staff to resident physical and verbal abuse. The CIR indicated that on a specific date, PSW staff witnessed, while an RPN was attempting to administer medications to resident #006, the RPN was threatening, using profanity, and hitting the resident with a shoe when the resident refused to take the medications.

During an interview with Inspector #573, PSW #107 stated that on a specific date, during their shift, PSW #107 witnessed that RPN #129 was yelling and using profanity at resident #006, insisting the resident take medications. Further, PSW #107 witnessed that RPN #129 physically hit the resident with a shoe more than once. PSW #107 stated that resident #006 was not calling out, but appeared to be in pain while RPN #129 hit the resident with the shoe. The PSW indicated to Inspector #573 that the resident was upset, angry and agitated with RPN #129's actions. The PSW indicated that they felt RPN #129's actions were both verbally and physically abusive towards the resident. The PSW stated to the inspector that they did not report this incident to their supervisor, nor to anyone. Furthermore, PSW #107 stated that in the past during their shift, the PSW observed RPN #129 being rude and yelling at a resident on their unit, but did not recall the name of the resident. The PSW confirmed with the inspector that they did not report the incident at that time to their supervisor.

During an interview with Inspector #573, PSW #126 stated that on a specific date, during evening hours, the PSW witnessed RPN #129 attempting to administer medications to resident #006. RPN #129 was using profanity, threatening the resident, and hitting the resident with a shoe. The PSW indicated that RPN #129 was insisting the resident take the medications after the resident said they didn't want to take them. The PSW indicated that they felt RPN #129's actions were both verbally and physically abusive towards the resident. The PSW indicated to

Inspector #573 that the resident was angry and agitated with RPN #129's actions. The PSW stated to the inspector, that at the time, they did not report this incident to their supervisor. Furthermore, PSW #126 stated that in the past during their shift, the PSW observed RPN #129 using profanity, referring to resident #016. The PSW confirmed with the inspector that they did not report the incident at that time to their supervisor.

During the interview, PSW #126 indicated to Inspector #573 that on a specific date, in the afternoon hours in the staff room, they discussed with their PSW co-workers regarding the witnessed staff to resident abuse incident and sought their opinion regarding reporting. PSW #126 indicated to the PSWs that a resident was hit with a shoe by a staff member. PSW #126 stated to the inspector that no names of the resident, nor the staff, were shared with the PSWs. Furthermore, PSW #126 indicated to the inspector that PSWs advised to report the incident to their supervisor.

PSW #126 and PSW #107 indicated awareness that they failed to follow the home's abuse prevention policy which requires that abuse of a resident is to be reported immediately to their supervisor and that it must also be reported immediately to the MOHLTC. PSW #126 indicated to the inspector that they were scared of the consequences and fearful of retaliation from their co-workers for not reporting the incident.

Inspector #573 spoke with RPN #130, who stated that on a specific date, evening hours in the Unit, PSW #126 discussed with the RPN regarding the witnessed staff to resident verbal and physical abuse incident that occurred recently and sought their opinion regarding reporting. RPN #130 indicated to the inspector that they advised PSW #126 to report the incident. Further, RPN #130 confirmed with the inspector that they did not report the incident to their supervisor, nor the Ministry of Health and Long-Term Care.

During an interview with Inspector #573, PSW #110 indicated to inspector that on a specific date, afternoon hours in the staff room, PSW #126 discussed in the presence of PSW #100 and PSW #117 regarding a witnessed staff to resident physical abuse incident that occurred recently. PSW #126 indicated to PSW #110 that a resident was hit with a shoe by a staff member. PSW #110 stated that PSW #126 did not provide any name of the staff nor the resident who was involved in the incident. PSW #110 stated that they shared this information with RPN #125 on the unit on a specific date. Furthermore, PSW #110 indicated that

RPN #125 stated to them that this incident should be reported.

During this inspection, Inspector #573 conducted a separate interview with PSW #100 and PSW #117 regarding the alleged incident. The PSWs indicated to the inspector that they all suspected that staff to resident abuse might have occurred. PSW #117 indicated to the inspector that they advised PSW #126 to report the incident. PSW #117 confirmed with the inspector that they did not report the incident to their supervisor. PSW #100 stated that they shared this information with RPN #125 on the unit on a specific date.

Inspector spoke with RPN #125, who stated that on a specific date, no details nor information were discussed by PSW #110 and PSW #100. Furthermore, the RPN denied that they mentioned to the PSWs regarding to report a staff to resident's abuse incident.

Inspector #573 reviewed the documents related to the licensee's investigation into the identified alleged incidents of abuse.

- On a specific date, during morning hours, RPN #131 overheard conversation between PSW #110 and PSW #124 regarding an allegation of staff to resident verbal and physical abuse that occurred recently on an evening shift. Furthermore, the RPN reported to In-charge RN regarding an allegation of staff to resident verbal and physical abuse.

- On a specific date, In-charge RN reported the allegation of staff to resident verbal and physical abuse to the designated manager on call. On the same day, the on call manager reported the incident of abuse to the Director of Care and the Administrator.

- On a specific date, the MOHLTC Info line – LTC after hours was contacted to report an incident of alleged staff to resident verbal and physical abuse.

Inspector #573 spoke with the Administrator, who indicated that on a specific date, the manager on call and the DOC reported allegation of RPN #129 to resident #006 witnessed verbal and physical abuse incident. The Administrator stated to the inspector that on a specific date, resident #006 was assessed for physical injuries and no visible signs of physical injury was observed. Further, resident #006 did not have any recollection of the abuse incident. The

Administrator stated to the inspector that on a specific date, an investigation was initiated immediately, resident #006's SDM, MOHLTC info-line, and police were notified. The Administrator indicated to the inspector that RPN #129 worked on a specific date, the day following the incident, on the same unit providing care to resident #006. When the allegation of resident's abuse was reported on a specific date, RPN #129 was not scheduled to work. Further, RPN #129 was called and placed on investigation leave. The Administrator stated to the inspector that the internal investigation confirmed that staff to resident verbal and physical abuse occurred. The Administrator stated to the inspector that RPN #129 was no longer employed by the licensee and Ontario College of Nursing was notified.

As such, the licensee failed to protect resident #006 from abuse in that: RPN #129 did not comply with the licensee's Prevention of Resident Abuse or Neglect policy to promote zero tolerance of abuse and neglect of residents. This Inspection indicated that alleged RPN #129 to resident abuse took place more than once, and was not immediately reported by the PSWs who witnessed it. RPN #129 was providing care and services to the residents on the unit until the staff was placed on investigation leave. As a result, the licensee failed to prevent resident abuse from RPN #129.

The licensee also failed to comply with:

1. LTCHA, s. 6. (7) the licensee failed to ensure that the care set out in the plan of care was provided to resident #006 as specified in the plan. (refer to WN #3)

2. LTCHA, s. 20 (1) the licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with. (refer to WN #4)

3. LTCHA, s. 24 (1) the licensee failed to ensure that the person who had reasonable grounds to suspect abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director. (refer to WN #5)
(Log #003156-18) [s. 19. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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 licensee has failed to ensure that the care set out in the plan of care was provided as specified in the plan.

A CIR was submitted to the MOHLTC related to staff to resident witnessed physical and verbal abuse.

Inspector #573 reviewed resident #006's written plan of care in place at the time of incident for responsive behaviours which indicated that staff allow resident time to respond to the directions, not to argue/ condemn resident. Furthermore, it indicated that resident can be verbally and physically responsive in situations if the resident feels no choice/ no control in the situations and usually able to re-approach later with effect.

During an interview with Inspector #573, PSW #107 and PSW #126 stated that on a specific date, during evening hours, the PSWs witnessed staff to resident abuse while RPN #129 was attempting to administer medications to resident #006. PSW #126 indicated that RPN #129 was forcing the resident to take the medications. The PSWs stated to Inspector #573 that the resident was angry and agitated with RPN #129's actions.

Inspector #573 spoke with the DOC, who indicated that on a specific date, RPN #129 was insisting resident #006 take the medications. Further, the DOC stated that RPN #129 failed to follow resident #006's written plan of care for responsive behaviours, when the resident was refusing their medications.

As such, RPN #129 did not provide resident #006's care regarding the responsive behaviours, as specified in the plan of care.
(Log #003156-18) [s. 6. (7)]

WN #4: 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 has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Inspector #573 reviewed the licensee's policy titled Prevention of Resident Abuse or Neglect, policy #G-006, dated October 1995, Revision Date February 27, 2019. The policy introduction statement stated that "Safety is a fundamental aspect of quality health care". Further, the policy stated that in keeping with the above statement Miramichi Lodge promotes zero tolerance of abuse and neglect of residents. The policy indicated that anyone who witnesses any form of abuse/neglect/inappropriate care, or is aware of alleged or suspected abuse/neglect/inappropriate care is responsible for reporting it to their supervisor or designate immediately. The policy further indicated that when abuse or inappropriate care is suspected, the following four steps should be followed:
A) Intervene
B) Report; and
C) Investigate
D) Document objective facts.

On a specific date, the MOHLTC Info line – LTC after hours was contacted by the licensee to report an incident of alleged staff to resident verbal and physical abuse.

On a specific date, a CIR was submitted to the MOHLTC related to staff to resident witnessed physical and verbal abuse. The CIR indicated that on a specific date, PSW staff witnessed, while an RPN was attempting to administer medications to resident #006, the RPN was threatening, using profanity, and hitting the resident with a shoe when the resident refused to take the medications.

As cited in evidence above WN #2, RPN #129 did not comply with the licensee's Prevention of Resident Abuse or Neglect policy to promote zero tolerance of

abuse and neglect of residents. The above noted PSW and RPN staff members failed to immediately report all alleged, suspected or witnessed incidents of abuse and neglect of residents as per the licensee Prevention of Resident Abuse or Neglect policy.

During an interview with Inspector #573, the Administrator stated to Inspector #573 that on a specific date, an investigation was initiated immediately. The Administrator stated to the inspector that the internal investigation confirmed that RPN #129 to resident #006 verbal and physical abuse occurred. Furthermore, the Administrator indicated to inspector that the staff members who witnessed resident #006's abuse and suspected the resident abuse might have occurred, did not immediately report the incident as per the licensee Prevention of Resident Abuse or Neglect, policy.
(Log #003156-18) [s. 20. (1)]

WN #5: 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 a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

On a specific date, the MOHLTC Info line – LTC after hours was contacted by the licensee to report an incident of alleged staff to resident verbal and physical abuse.

On a specific date, a CIR was submitted to the MOHLTC related to staff to resident witnessed physical and verbal abuse. The CIR indicated that on a specific date, PSW staff witnessed, while an RPN was attempting to administer medications to resident #006, the RPN was threatening, using profanity, and hitting the resident with a shoe when the resident refused to take the medications.

As cited in evidence above WN #2, the staff members who witnessed resident #006's abuse and the staff members who suspected that resident #006 abuse had or might had occurred failed to report the incident to the MOHLTC Director immediately as per the LTCHA section 24.

During an interview with Inspector #573, the Administrator stated to Inspector #573 that RPN staff supervise PSW staff on the units. Furthermore, the Administrator indicated that if the staff members witness, or suspect resident abuse have or might have occurred, they should immediately reported the incident to their supervisor and that it must also be reported immediately to the Ministry of Health and Long-Term Care.
(Log #003156-18) [s. 24. (1)]

(A1)
The following Non-Compliance has been Revoked: WN #1

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).

Issued on this 21st day of May, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by EMILY BROOKS (732) - (A1)
Inspection No. / No de l'inspection :	2019_785732_0006 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	003156-18, 006165-18, 008739-18, 010589-18, 011041-18, 017976-18, 019196-18, 026655-18, 029305-18, 032311-18, 002567-19, 003526-19, 005536-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 21, 2019(A1)
Licensee / Titulaire de permis :	The Corporation of the County of Renfrew 9 International Drive, PEMBROKE, ON, K8A-6W5
LTC Home / Foyer de SLD :	Miramichi Lodge 725 Pembroke Street West, PEMBROKE, ON, K8A-8S6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Mike Blackmore

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To The Corporation of the County of Renfrew, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

(A1)
The following Order(s) have been rescinded:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Linked to Existing Order/ Lien vers ordre existant :

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s.19 (1) of the LTCHA

The licensee shall prepare, submit, and implement a plan to ensure that;

1) All staff are educated on zero tolerance of abuse and neglect of residents. The Licensee shall ensure that a documented record of the educational program is kept in the home that includes the date, subject heading, educational content, and the name of the staff who has been educated.

At minimum, this education must include, but not limited to:
- as defined by O. Reg 79/10, section 2 (1) (2) (3), definitions of abuse
- as outlined in LTCHA, section 24, mandatory reporting requirements
- a review of all the aspects of the Licensee's written policy related to Prevention of Resident Abuse or Neglect G-006
- a review of the Licensee's written policy and procedure related to Staff Reporting and Whistleblowing Protection G-007

2. The written policy titled Prevention of Resident Abuse or Neglect G-006 and Staff Reporting and Whistleblowing Protection G-007, is effectively implemented by:

-verifying that staff demonstrate knowledge of what constitutes resident abuse and the requirement/process for immediate reporting of any alleged, witnessed, or suspected resident abuse and neglect to their supervisor and to the Ministry of Health and Long- Term Care.
-ensuring that all staff demonstrate a clear understanding of the whistle-blowing protection under s.26 of the LTCH Act, 2007.

Please submit the written plan for achieving compliance for 2019_785732_0006 to Anandraj (Andy) Natarajan, LTC Homes Inspector, MOHLTC, by email to OttawaSAO.MOH@ontario.ca by May 7, 2019. Please ensure that the submitted written plan does not contain any personal information or personal health information.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #006 was protected from abuse by the licensee or staff in the home.

In accordance with O.Reg. 79/10, section 2, verbal abuse means, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

In accordance with O.Reg. 79/10, section 2, physical abuse means, the use of physical force by anyone other than a resident that causes physical injury or pain.

On a specific date, The Ministry of Health and Long-Term Care (MOHLTC) Info line – LTC after hours was contacted by the licensee to report an incident of alleged staff to resident verbal and physical abuse.

The next day, a Critical Incident Report (CIR) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to staff to resident physical and verbal abuse. The CIR indicated that on a specific date, PSW staff witnessed, while an RPN was attempting to administer medications to resident #006, the RPN was threatening, using profanity, and hitting the resident with a shoe when the resident refused to take the medications.

During an interview with Inspector #573, PSW #107 stated that on a specific date, during their shift, PSW #107 witnessed that RPN #129 was yelling and using profanity at resident #006, insisting the resident take medications. Further, PSW #107 witnessed that RPN #129 physically hit the resident with a shoe more than once. PSW #107 stated that resident #006 was not calling out, but appeared to be in pain while RPN #129 hit the resident with the shoe. The PSW indicated to Inspector #573 that the resident was upset, angry and agitated with RPN #129's actions. The PSW indicated that they felt RPN #129's actions were both verbally and physically abusive towards the resident. The PSW stated to the inspector that they did not report this incident to their supervisor, nor to anyone. Furthermore, PSW #107 stated that in the past during their shift, the PSW observed RPN #129 being rude and yelling at a resident on their unit, but did not recall the name of the resident. The PSW confirmed with the inspector that they did not report the incident at that time to their supervisor.

During an interview with Inspector #573, PSW #126 stated that on a specific date,

during evening hours, the PSW witnessed RPN #129 attempting to administer medications to resident #006. RPN #129 was using profanity, threatening the resident, and hitting the resident with a shoe. The PSW indicated that RPN #129 was insisting the resident take the medications after the resident said they didn't want to take them. The PSW indicated that they felt RPN #129's actions were both verbally and physically abusive towards the resident. The PSW indicated to Inspector #573 that the resident was angry and agitated with RPN #129's actions. The PSW stated to the inspector, that at the time, they did not report this incident to their supervisor. Furthermore, PSW #126 stated that in the past during their shift, the PSW observed RPN #129 using profanity, referring to resident #016. The PSW confirmed with the inspector that they did not report the incident at that time to their supervisor.

During the interview, PSW #126 indicated to Inspector #573 that on a specific date, in the afternoon hours in the staff room, they discussed with their PSW co-workers regarding the witnessed staff to resident abuse incident and sought their opinion regarding reporting. PSW #126 indicated to the PSWs that a resident was hit with a shoe by a staff member. PSW #126 stated to the inspector that no names of the resident, nor the staff, were shared with the PSWs. Furthermore, PSW #126 indicated to the inspector that PSWs advised to report the incident to their supervisor.

PSW #126 and PSW #107 indicated awareness that they failed to follow the home's abuse prevention policy which requires that abuse of a resident is to be reported immediately to their supervisor and that it must also be reported immediately to the MOHLTC. PSW #126 indicated to the inspector that they were scared of the consequences and fearful of retaliation from their co-workers for not reporting the incident.

Inspector #573 spoke with RPN #130, who stated that on a specific date, evening hours in the Unit, PSW #126 discussed with the RPN regarding the witnessed staff to resident verbal and physical abuse incident that occurred recently and sought their opinion regarding reporting. RPN #130 indicated to the inspector that they advised PSW #126 to report the incident. Further, RPN #130 confirmed with the inspector that they did not report the incident to their supervisor, nor the Ministry of Health and Long-Term Care.

During an interview with Inspector #573, PSW #110 indicated to inspector that on a

specific date, afternoon hours in the staff room, PSW #126 discussed in the presence of PSW #100 and PSW #117 regarding a witnessed staff to resident physical abuse incident that occurred recently. PSW #126 indicated to PSW #110 that a resident was hit with a shoe by a staff member. PSW #110 stated that PSW #126 did not provide any name of the staff nor the resident who was involved in the incident. PSW #110 stated that they shared this information with RPN #125 on the unit on a specific date. Furthermore, PSW #110 indicated that RPN #125 stated to them that this incident should be reported.

During this inspection, Inspector #573 conducted a separate interview with PSW #100 and PSW #117 regarding the alleged incident. The PSWs indicated to the inspector that they all suspected that staff to resident abuse might have occurred. PSW #117 indicated to the inspector that they advised PSW #126 to report the incident. PSW #117 confirmed with the inspector that they did not report the incident to their supervisor. PSW #100 stated that they shared this information with RPN #125 on the unit on a specific date.

Inspector spoke with RPN #125, who stated that on a specific date, no details nor information were discussed by PSW #110 and PSW #100. Furthermore, the RPN denied that they mentioned to the PSWs regarding to report a staff to resident's abuse incident.

Inspector #573 reviewed the documents related to the licensee's investigation into the identified alleged incidents of abuse.

- On a specific date, during morning hours, RPN #131 overheard conversation between PSW #110 and PSW #124 regarding an allegation of staff to resident verbal and physical abuse that occurred recently on an evening shift. Furthermore, the RPN reported to In-charge RN regarding an allegation of staff to resident verbal and physical abuse.

- On a specific date, In-charge RN reported the allegation of staff to resident verbal and physical abuse to the designated manager on call. On the same day, the on call manager reported the incident of abuse to the Director of Care and the Administrator.

- On a specific date, the MOHLTC Info line – LTC after hours was contacted to report

an incident of alleged staff to resident verbal and physical abuse.

Inspector #573 spoke with the Administrator, who indicated that on a specific date, the manager on call and the DOC reported allegation of RPN #129 to resident #006 witnessed verbal and physical abuse incident. The Administrator stated to the inspector that on a specific date, resident #006 was assessed for physical injuries and no visible signs of physical injury was observed. Further, resident #006 did not have any recollection of the abuse incident. The Administrator stated to the inspector that on a specific date, an investigation was initiated immediately, resident #006's SDM, MOHLTC info-line, and police were notified. The Administrator indicated to the inspector that RPN #129 worked on a specific date, the day following the incident, on the same unit providing care to resident #006. When the allegation of resident's abuse was reported on a specific date, RPN #129 was not scheduled to work. Further, RPN #129 was called and placed on investigation leave. The Administrator stated to the inspector that the internal investigation confirmed that staff to resident verbal and physical abuse occurred. The Administrator stated to the inspector that RPN #129 was no longer employed by the licensee and Ontario College of Nursing was notified.

As such, the licensee failed to protect resident #006 from abuse in that: RPN #129 did not comply with the licensee's Prevention of Resident Abuse or Neglect policy to promote zero tolerance of abuse and neglect of residents. This Inspection indicated that alleged RPN #129 to resident abuse took place more than once, and was not immediately reported by the PSWs who witnessed it. RPN #129 was providing care and services to the residents on the unit until the staff was placed on investigation leave. As a result, the licensee failed to prevent resident abuse from RPN #129.

The licensee also failed to comply with:

1. LTCHA, s. 6. (7) the licensee failed to ensure that the care set out in the plan of care was provided to resident #006 as specified in the plan. (refer to WN #3)

2. LTCHA, s. 20 (1) the licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with. (refer to WN #4)

3. LTCHA, s. 24 (1) the licensee failed to ensure that the person who had reasonable grounds to suspect abuse of a resident by anyone has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director. (refer to WN #5)
(Log #003156-18)

A Compliance Order was issued based on the severity of actual harm/ risk to the resident.

(573)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 16, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 21st day of May, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by EMILY BROOKS (732) - (A1)

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Service Area Office / Bureau régional de services : Ottawa Service Area Office