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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 25, 2018	2018_765541_0016	008364-18, 008536-18, 008712-18, 009664-18, 010693-18, 010847-18, 010884-18, 011233-18, 011610-18, 012494-18, 013931-18, 016605-18, 016616-18, 016896-18, 016965-18, 017084-18, 017341-18, 019928-18, 020232-18, 020913-18	Critical Incident System

Licensee/Titulaire de permis

AON Inc.
307 Aylmer Street PETERBOROUGH ON K9L 7M4

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

Moira Place Long-Term Care Home
415 River Street West P.O. Box 200 TWEED ON K0K 3J0

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

AMBER LAM (541)

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): September 19-21 and 26-27, 2018

The following intakes were completed during this inspection:

008364-18 (Critical Incident # 2977-000011-18) - a fall resulting in a significant change in status
008536-18 (Critical Incident # 2977-000014-18) - resident to resident physical abuse
008712-18 (Critical Incident # 2977-000015-18) - resident to resident physical abuse
009664-18 (Critical Incident # 2977-000016-18) - resident to resident physical abuse
010847-18 (Critical Incident #2977-000019-18) - resident to resident physical abuse
010884-18 (Critical Incident # 2977-000020-18) - resident to resident physical abuse
011233-18 (Critical Incident # 2977-000021-18) - resident to resident physical abuse
016616-18 (Critical Incident # 2977-000027-18) - resident to resident physical abuse
016965-18 (Critical Incident # 2977-000028-18) - resident to resident physical abuse
017084-18 (Critical Incident # 2977-000029-18) - resident to resident physical abuse
017341-18 (Critical Incident # 2977-000030-18) - resident to resident physical abuse
012494-18 (Critical Incident # 2977-000023-18) - resident to resident physical abuse
013931-18 (Critical Incident # 2977-000025-18) - resident to resident physical abuse
016605-18 (Critical Incident #2977-000026-18) - a resident missing less than 3 hours

020913-18 (Critical Incident # 2977-000034-18) - a resident missing less than 3 hours
016896-18 (Critical Incident # 2977-000031-18) - a resident missing less than 3 hours
011610-18 (Critical Incident # 2977-000022-18) - resident to resident sexual abuse
019928-18 (Critical Incident # 2977-000032-18) - resident to resident sexual abuse
020232-18 (Critical Incident # 2977-000033-18) - resident to resident sexual abuse
010693-18 (Critical Incident # 2977-000018-18) - resident to resident sexual abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses, Registered Practical Nurses and Personal Support Workers. In addition the inspector reviewed resident health care records including incident reports, plans of care, fall assessments and behavioral assessments. The inspector also observed resident to resident and resident to staff interactions.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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. 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 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:
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.

Re: log #010693 (Critical Incident #2977-000018-18) and log #011610-18 (Critical Incident #2977-000022-18)

As per O. Reg 79/10 s. 2(1) "sexual abuse" means any non-consensual touching, behavior or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

According to CI #2977-000022-18, on a specified date resident #003 was observed to walk up behind resident #009 and touch the resident on the on the buttocks in a public area.

According to CI #2977-000018-18, on a specified date resident #003 was observed to have their hands down the pants of resident #010 in a public area.

On the two specified dates, RPN #107 was working on the unit where the residents

#003, #009 and #010 reside. Inspector #541 interviewed RPN #107 who indicated that upon becoming aware of the incidents with resident #003, the RPN notified the charge nurse and completed an incident report. RPN #107 indicated the incident report is an internal report completed to notify management.

During an interview with the DOC, they indicated they review the incident reports each morning and became aware of CI #2977-000022-18 and CI #2977-000018-18 on the morning after each incident occurred. The DOC further indicated they did not believe the incidents required reporting and it was not until the Administrator reviewed the reports 8 and 13 days later, that the incidents were reported to the Director via the Critical Incident System. [s. 24. (1)]

2. Re: Log #019928-18 (Critical Incident #2977-000032-18)

On a specified date, a progress note stated that resident #004 was walking in the hallway and "made a sexual comment to resident #011". According to a description of the incident in CI #2977-000032-18, resident #004 said to resident #011 “if the PSW is busy I can shower you.” Resident #011 was noted to be upset about this comment.
The Director was not notified of this incident until four days after the incident occurred. During an interview with Inspector #541 the DOC indicated this incident was reported late as RPN who was working on the unit that day was new and was not aware of the reporting requirement. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the person who has 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:
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, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.

Re: Log #020913-18 (Critical Incident #2977-000034-18)
On a specified date, the home received a phone call from a member of the community stating that resident #007 was at their house and the person would be returning the resident to the home. The resident had gone outside of the home for a walk and ended up leaving the grounds, walking down the sidewalk to a neighbors house.

The incident was not reported to the Director until three business days later. The DOC indicated during an interview with Inspector #541 that the incident was noted on a 24 hour shift report however the DOC was not working that week and first became aware of the incident upon reviewing the report three days later when the DOC returned to work. [s. 107. (3) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the Director is informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Re: log #010693 (Critical Incident #2977-000018-18) and log #011610-18 (Critical Incident #2977-000022-18)

As per O. Reg 79/10 s. 2(1) "sexual abuse" means any non-consensual touching, behavior or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

According to CI #2977-000022-18, on a specified date resident #003 was observed to walk up behind resident #009 and touch the resident on the on the buttocks in a public area.

According to CI #2977-000018-18, on a specified date, resident #003 was observed to have their hands down the pants of resident #010 in a public area.

On October 4, 2018 the home confirmed that the police were not notified until 13 and 14 days later for the two incidents noted above. [s. 98.]

Issued on this 29th day of October, 2018

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

Original report signed by the inspector.