Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 1, 2017	2017_664602_0030	012243-17, 013197-17, 014028-17, 014819-17, 022630-17	Critical Incident System

Licensee/Titulaire de permis

2109577 ONTARIO LIMITED
195 Forum Drive Unit 617 MISSISSAUGA ON L4Z 3M5

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

2109577 ONTARIO LIMITED O/A ARBOUR HEIGHTS
564 Tanner Drive KINGSTON ON K7M 0C3

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

WENDY BROWN (602)

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 25 & 26 and November 8-10 & 14-15, 2017

5 Critical Incidents were inspected as follows:
012243-17 concerning a fall with injury resulting in hospitalization.
013197-17 concerning staff to resident verbal and physical abuse.
014028-17 concerning a fall with injury resulting in hospitalization.
014819-17 concerning a fall with injury resulting in hospitalization.
022399-17 & 022630-17 concerning staff to resident verbal and physical abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care, Registered Nurses (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the RN Manager, a Private Caregiver, family members and residents. In addition the inspector reviewed resident health care records, the Reporting & Complaints and the Prevention of Abuse/Neglect policies, and various complaint forms and letters. The inspector also observed staff and resident care interactions and resident care and services.

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

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan

On a specified date resident #004 was in the hallway and fell. A post fall assessment was completed; one injury was noted. Later that day resident #004 was transferred to hospital and admitted with further injuries. Resident #004 passed away in hospital after a specified period.

Resident #004 had been assessed as at high risk for falling and had a care plan developed with consideration of numerous resident-specific conditions. Prior to resident #004's fall there had been a number of falls recorded over a specified period. There were several fall management interventions in place.

Post fall investigation notes indicate that the Director of Care (DOC) reviewed video surveillance in an effort to further determine causative factors for the fall. In an interview on a specified date, the DOC confirmed that she observed via video that one of the fall interventions had been neglected. The staff who forgot to ensure the fall intervention was in place were "disciplined and re-educated". Staff did not provide care as per plan of care as they neglected a fall intervention which resulted in the resident's fall and injuries. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in a resident's plan of care, specifically fall prevention strategies, are provided to the resident as specified in their plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. 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).

Log # 013197-17 and 022630-17

The licensee's "Resident Abuse prevention” document that all employees must complete and sign at hire states that “it is an expectation at [the home] that all residents will be treated with dignity and respect by staff… Residents will have their rights promoted and respected at all times. … Examples of abuse include:
- Unauthorized use of physical force or restraint
- Handling a resident roughly or administering a treatment roughly
- Verbal abuse … which threatens the resident causes annoyance or discomfort".

By signing this document employees make “a commitment to the prevention of resident abuse at the home”. Unit 17 – "Zero tolerance of abuse and neglect of residents" orientation education outlines that the home “is committed to a zero tolerance of abuse or neglect of its residents”.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act:
- Physical abuse is defined in O.Reg 79/10 s. 5 as the use of physical force by anyone other than a resident that causes physical injury or pain, and/or administering or withholding a drug for an inappropriate purpose, and/or the use of physical force by a resident that causes physical injury to another resident.
- Verbal Abuse includes any form of verbal communication of a belittling or degrading nature which may diminish the resident's sense of well-being, dignity or self-worth made

by anyone other than a resident. Verbal abuse also includes any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences.

On a specified date a complaint was made by a staff regarding the care provided to resident #002 by a co-worker. The complainant indicated that while providing care for resident #002 the co-worker held tightly on to the resident, made an abusive & threatening comment to the resident and then struck the resident with open hand.

The critical incident report and the home's investigation file indicated that staff immediately reported the concern to the RN Manager.

A physical assessment of resident # 002 was completed. An investigation was initiated and the abusive staff was placed on leave for the duration of the investigation. The physician, Director, POA, and the Police were all alerted to the incident. In an interview on a specified date, the ADOC indicated that all re-education was completed with staff on or before a specified date.   The investigation concluded that the staff member acted with excessive force during care.

2. On a specified date a caregiver called for assistance of PSW staff #110 with resident #001 who needed help. The PSW staff #110 was noted to be "visibly irritated" when entering the room. The PSW staff proceeded to move resident #001with such speed and force that the resident's head was bouncing off of the pillow. PSW #110 was reported to manoeuvre resident #001 back and forth so rapidly that the resident's caregiver could not assist in care provision. Once PSW#110 finished the care she scolded the resident verbally.

In an interview with the caregiver regarding the incident, inspector #602 confirmed that PSW #110 was rough with resident #001, grabbing at the resident, flipping the resident back and forth, and verbally abusing the resident in front of the caregiver; who appeared shaken while reviewing what was witnessed.

The Director of Care advised inspector #602 that PSW #110 had been found to act with excessive force with another resident a specified period before this incident. The PSW had been disciplined as well as provided 1:1 re-education for care of LTC home residents at the time of the first incident. A review of PSW #110's education documentation revealed that annual resident abuse, abuse prevention policy and procedure refreshes

were completed with PSW#110 on a specified date and then again on another specified date following the first abuse incident. The DOC explained that given the second incident of abuse with resident #001 and the previous abuse incident with resident #002, PSW#110 was terminated.

A PSW staff failed to comply with the home's abuse policy prevention measures and strategies outlined in their Abuse Policy ADM-VI-06 pages 9 & 10 in the Administration Manual in that they failed to respect their signed commitment to the prevention of resident abuse at the facility by verbally and physically abusing resident #002 in June 2017 and again,10 weeks later, with resident #001 in September 2017. [s. 20. (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 staff comply with the Resident Abuse prevention zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents receive training relating to abuse recognition and prevention annually

On a specified date the home's investigation concluded that PSW staff member #110 acted with excessive force while caring for resident #002. PSW #110 was disciplined for use of excessive force and was provided 1:1 re-education for care of residents, resident abuse, and ways to de-escalate situations. A review of PSW #110's education documentation revealed that the last annual resident abuse, abuse prevention policy and procedure refresh was completed on a specified date; a specified period after the annual retraining deadline; thus the annual training requirement was not met. [s. 221. (2)]

Issued on this 1st day of December, 2017

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

Original report signed by the inspector.