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

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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
Jan 10, 2018	2017_520622_0045	021689-17, 022302-17, 023427-17	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

HEATH HEFFERNAN (622)

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): December 18 - 22, 2017, December 28, 29, 2017 and January 2 - 5, 2018.

Log #023427-17 related to alleged staff to resident abuse.
Log #022302-17 related to alleged improper/incompetent treatment of a resident.
Log #021689-17 related to alleged resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Nurse Manager, Registered Nurse (RN), Registered Practical Nurses (RPN), Personal Care Providers (PCP) and residents.

Also during the course of the inspection, the inspector reviewed the applicable Critical Incident System (CIS) reports, health records of identified residents in addition to the homes investigation documentation and the homes abuse policy # ADM-VI-06. The Inspector observed resident care and services, along with resident to resident and staff to resident interaction.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
1 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. This finding of non-compliance is related to a Critical Incident System report (CIS).

The Licensee has failed to ensure that the person who had reasonable grounds to suspect that improper or incompetent treatment of care for resident #004 that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director?

CIS report indicated that an alleged incident of improper/incompetent treatment of resident #004 occurred on a specified date. Personal Care Provider (PCP) #105 indicated she had reported to Registered Practical Nurse (RPN) #109 that resident #004 required specified intervention and assessment. On a specified date, PCP #105 reported that RPN #109 had failed to follow up with the concerns related to resident #004. The CIS report was first submitted by DOC #103 three days post incident.

A review of documentation related to the homes internal investigation dated on a specified date indicated:
- On a specified date the alleged concern of improper/incompetent treatment of resident #004 was reported to the management that RPN #109 had not tended to resident #004's care needs.
- On a specified date two days post incident, management reviewed video footage which confirmed the allegations reported by the PSW. The video indicated RPN #109 had not

tended to resident #004's care needs on the specified date.

On a specified date, inspector #622 interviewed DOC #103 who indicated she had not reported the alleged incident of improper/incompetent treatment of resident #004 until a specified date three days after incident as she had not determined that the improper/ incompetent care of resident #004 had occurred until that date. Further interview with DOC #103 indicated that on a specified date two days after incident, she had reviewed video footage related to the alleged incident of improper/incompetent treatment of resident #004 and determined RPN #109 had not provided the assessment and care required for resident #004 as alleged by PSW #105.

On a specified date, inspector #622 interviewed the Administrator who indicated that if DOC #103 said she watched video footage related to the alleged improper/incompetent treatment of resident #004 from the specified date and made the determination that the incident of alleged improper/incompetent treatment related to resident #004 had occurred as reported, then it should have been reported on that date and not a day later. [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 any person who has reasonable grounds to suspect that abuse of a resident has occurred or may occur, immediately reports the suspicion and the information upon which it is based to the Director,, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. This finding of non-compliance is related to a Critical Incident System report (CIS).

The Licensee has failed to ensure that in making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
Actions taken in response to the incident, including what care was given or action taken as a result of the incident and the outcome or current status of the individual or individuals who were involved in the incident.

The CIS report dated on a specified date indicated resident #003 was found with a minor injury. It was unknown if the injury was caused by a co-resident or staff. The report indicated the category of incident was physical abuse.

Further review of the amended CIS report dated a specified date, indicated that staff were interviewed and the cause of the minor injury was undetermined. There was no documentation on the CIS report of the care and assessment resident #003 received as a result of the incident or the outcome/current status of the resident. The sections on the CIS report for documentation of the outcome/current status of the individual involved indicated only “Investigation Pending”.

On a specified date during an interview with inspector #622, DOC #103 reviewed the CIS report and indicated that the statement “investigating pending” would normally not be left in the final amended copy. DOC #103 indicated the CIS report did not include documentation for the care, assessment and the outcome/current status of resident #003 as a result of the incident. [s. 104. (1) 3.]

Issued on this 10th day of January, 2018

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

Original report signed by the inspector.