Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 4, 2019	2019_657681_0027	016945-19	Critical Incident System

Licensee/Titulaire de permis

Board of Management for the District of Parry Sound West
21 Belvedere Avenue PARRY SOUND ON P2A 2A2

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

Belvedere Heights
21 Belvedere Avenue PARRY SOUND ON P2A 2A2

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

STEPHANIE DONI (681), AMY PAGE (749), TRACY MUCHMAKER (690)

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 30, 2019 - October 4, 2019. Additional off-site activities were completed on October 9, 16, and 17, 2019.

One intake, related to allegations of resident to resident abuse, was inspected during this Critical Incident inspection.

A Complaint inspection, #2019_657681_0026, was conducted concurrently with this inspection.

Inspector, Keara Cronin (#759), was present throughout the inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, former Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Physiotherapy Assistant (PTA), family members, and residents.

The Inspectors also conducted a tour of the resident care areas, reviewed relevant resident care records, home investigation notes, home policies and observed resident rooms, resident common areas, and the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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 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 #1: 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 has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident that the licensee knows of, or that was reported, was immediately investigated.

A Critical Incident System (CIS) report was submitted to the Director, related to allegations of resident to resident abuse. The CIS report identified that resident #002 had two incidents of inappropriate behaviour that occurred on two separate dates.

Inspector #690 reviewed the progress notes in resident #002's electronic medical record and identified a progress note, which indicated that resident #002 was observed by Staff Member #121 to have acted inappropriately towards resident #005. Staff Member #121 separated the residents and reported the incident to the RN.

The Inspector also identified a second progress note in resident #002's electronic medical record that was entered by Staff Member #128 on a different date. The progress note indicated that, at the start of Staff Member #128's shift, staff reported that resident #002 acted inappropriately towards resident #006.

During an interview with Staff Member #116, they stated that they were reviewing the progress notes in resident #002's electronic medical record when they identified the progress notes related to the incidents. Staff Member #116 indicated that they could not find incident reports for the two incidents, so they sent an email to the DOC to make

them aware of what had occurred.

The Inspector reviewed the home's policy titled "Prevention of Abuse and Neglect ZERO Tolerance", which indicated that the CEO/DOC/Manager on Call or Registered Nurse shall investigate all incidents of alleged, suspected or witnessed abuse. The policy further indicated that all aspects of the investigation would be documented on the incident report.

In separate interviews with Staff Member #112 and Staff Member #113, they indicated that if there was an incident of alleged abuse, the Registered Staff were to complete an incident report.

In an interview with Staff Member #127, they indicated that Staff Member #121 made them aware of the first incident that occurred involving resident #002. Staff Member #127 was unable to recall if they had completed an incident report or documented the incident on the 24-hour high-risk event list.

In an interview with DOC #122, they stated that incident reports should have been completed by the Registered Staff. DOC #122 indicated that, when they were notified about the incidents, they spoke with Staff Member #121 about the first incident, but they were unable to speak with Staff Member #128 or obtain any further information about the second incident. (690) [s. 23. (1) (a)]

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 every alleged, suspected or witnessed incident of abuse of a resident, that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #2: 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 had reasonable grounds to suspect that abuse of a resident by anyone had occurred, immediately report the suspicion and the information upon which it was based to the Director.

A CIS report was submitted to the Director related to allegations of resident to resident abuse. Please refer to WN #1 for additional details.

A review of the home's policy titled "Prevention of Abuse and Neglect ZERO Tolerance", effective August 2018, indicated that anyone who had reasonable grounds to suspect that a resident had suffered or may have suffered abuse was required to report to the Registered Nurse, DOC, Chief Executive Officer, or Manager on Call immediately. The policy further indicated that the CEO/DOC would report the incident to the Ministry of Long-Term Care.

In separate interviews with Staff Members #112 and #113, they indicated that, if there was an incident of alleged abuse, the Registered staff were to immediately report the incident to the manager on call. Both Staff Members #112 and #113 indicated that it would be the manager on call or the DOC who would report the incident to the Ministry of Long-Term Care.

During an interview with Staff Member #127, they indicated that Staff Member #121 made them aware of the incident that occurred, but they did not report to the incident to the DOC.

During an interview with DOC #122, they stated that they submitted the CIS report for the allegations of abuse when they were made aware of the incidents that had previously occurred. The DOC indicated that the incidents should have been reported to themself or the manager on call when they occurred so that the DOC could have notified the Director immediately. [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 a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #3: 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. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that, when making a report to the Director related to an alleged, suspected or witnessed incident of abuse, a final report was provided to the Director within the time period specified by the Director.

Section 104 (1) of the Ontario Regulation 79/10, indicates that in making a report to the Director, the report shall include the following material in writing with respect to the alleged, suspected or witnessed incident of resident abuse:
- actions taken in response to the incident, including the outcome or current status of the individual or individuals involved in the incident; and
- analysis and follow-up action, including the immediate and long term actions to prevent recurrence.

A CIS report was submitted to the Director, related to two allegations of resident to resident abuse. The Director requested that the home amend the report to provide further details about the incident, including if there was harm to the residents involved. The Director requested that the amendment be submitted by a specified date.

Inspector #690 reviewed the CIS report and identified that the report failed to include information about whether any residents were harmed or the status of the individuals involved. The CIS report was not amended with the requested information by the date the Director requested.

2. A CIS report was submitted to the Director, related to an allegation of staff to resident abuse. The Director requested that the home amend the CIS report with the results of the investigation by a specified date.

Inspector #690 reviewed the CIS report and identified that the report failed to include information on the immediate and long-term actions taken to prevent recurrence, and the report indicated that the immediate and long-term actions "remained under investigation".

3. A CIS report was submitted to the Director, related to an allegation of staff to resident abuse. The Director requested that the home amend the CIS report with information related to a staff member's comments and the outcome of the home's investigation by a specified date.

Inspector #690 reviewed the CIS report and identified that the report failed to include information on comments made by the staff member or the results of the investigation. The home did not amend the CIS report by the date the Director requested.

In an interview with Inspector #690, DOC #122 indicated that they were aware that the CIS reports were to be amended with the requested information by the date specified by the Director, and they did not provide the requested information by the requested date. [s. 104. (3)]

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 when making a report to the Director under subsection 23 (2) of the Act, if not everything required can be provided in the report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director, to be implemented voluntarily.

WN #4: 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.

A CIS report was submitted to the Director, related to allegations of resident to resident abuse. Please refer to WN #1 for additional details.

Inspector #690 reviewed resident #002's electronic medical record and identified a progress note, which indicated that a specified intervention had been implemented.

A review of resident #002's current care plan identified that resident #002 was to have the specified intervention in place.

During observations on four consecutive dates, the Inspector did not observe the specified intervention.

In an interview with Inspector #690, Staff Member #112 indicated that resident #002 was to have a specified intervention in place, but they had not seen the intervention for quite some time. Staff Member #108 indicated that they would utilize a resident's care plan to find information related to behaviours and any interventions that were in place.

In an interview with Inspector #690, DOC #122 indicated that a specified intervention had been put in place for resident #002. DOC #122 indicated that care was not provided as specified in the resident's care plan because the intervention should have been in place. [s. 6. (7)]

Issued on this 6th day of November, 2019

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

Original report signed by the inspector.