Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jan 29, 2020	2019_752627_0027	022245-19	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

SYLVIE BYRNES (627), SHELLEY MURPHY (684), STEVEN NACCARATO (744)

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 16-20, 2019 and January 8-9, 2020. Additional off-site activities were completed on December 23, 27, 30-31, 2019, January 3 and 6-7, 2020.

The following intake was inspected during this Critical Incident System inspection:

- One intake related to staff to resident alleged physical abuse.

A Follow Up inspection, #2019_752627_0026 and a Complaint inspection, #2019_752627_0025, were completed concurrently during this inspection. PLEASE NOTE: written notifications and compliance orders related to LTCHA, 2007, s 20 (1) and s 24 (1), identified in this inspection, have been issued in the Complaint inspection report, #2019_752627_0025.

During the course of the inspection, the inspector(s) spoke with the previous Chief Executive Officer (CEO), previous Director of Care (DOC), Physician, Nurse Practitioner (NP), Nurse Managers (NM), Program Coordinators, Union President, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping staff, residents and family members.

The Inspectors also observed resident care areas, the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, internal investigation documents and policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **3 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	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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A Critical Incident System (CIS) report was submitted to the Director in regard to alleged abuse of resident #007 by Personal Support Worker (PSW) #110.

Inspector #684 reviewed resident #007's care plan that was in effect at the time of the incident. The care plan indicated that resident #007 required a specific level of assistance from staff members for mobility and transfers.

Inspector #684 reviewed the home's policy titled "Minimal Lift Policy", Policy Number H&S-5002, last revised December 2016, which stated: "1) Employees will comply with all aspects of the safe client handling program, and specifically the Minimal Lift Policy. 2) Employees will use proper techniques during lifts and transfers".

Inspector #684 interviewed housekeeper #114 regarding the incident involving resident #007. Housekeeper #114 stated that PSW #110 repositioned resident #007 differently from what the care plan indicated, when they had requested assistance repositoning resident #007.

Inspector #684 interviewed RPN #121 regarding transferring and positioning techniques to be used for resident #007. Inspector #684 asked if the repositoning of resident #007 was done as per their care plan to which RPN #121 responded “No”.

Inspector #684 interviewed Director of Care (DOC) #101 who stated that resident #007 was not properly repositioined by PSW #110. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision maker (SDM), if any, and any other person specified by the resident were notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

A CIS report was submitted to the Director for alleged abuse by PSW #110 toward a resident. Inspector #684 reviewed the CIS report which indicated that RPN #106 had submitted two emails in regard to the submission of the CIS report.

Inspector #684 reviewed the two emails sent by RPN #106 to DOC #101, which identified two separate incidences of potential abuse by PSW #110 toward resident #007 and resident #001.

Inspector #684 was unable to locate in the CIS report if the SDM for resident #007 had been notified of the incident.

Inspector #684 reviewed the progress notes for resident #007 for a five day period and failed to identify that the SDM was made aware of both incidents.

Inspector #684 reviewed the home’s policy “Prevention of Abuse and Neglect”, policy number: PER-2300, with an effective date of October 2015, which indicated:
The Director of Nursing Administration (DONA), Assistant Director of Resident Care (ADORC)/Registered Nurse shall:
-Notification of the resident’s family member or SDM when abuse of that resident has, or is suspected to have occurred.

During an interview with DOC #101, they informed Inspector #684 that the SDM should have been notified of the incident that involved resident #007, and that the notification should have been documented. (684) [s. 97. (1) (b)]

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. (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:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that when making a report to the Director under subsection 23 (2) of the Act, the licensee included 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:
-A description of the individuals involved in the incident, including the names of all residents involved in the incident;

A CIS report was submitted to the Director for abuse of a resident by PSW #110. Please see WN #1 for details.

Upon review of the CIS report, Inspector #684 noted that the report referenced two emails which were submitted to the home by RPN #106 in regards to the alleged abusive care of residents by PSW #110. The two emails indicated that two residents were involved; resident #001 and #007. The CIS report submitted identified one resident was involved; resident #001.

During an interview with housekeeper #114 they informed Inspector #684 that resident #007 was repositioned improperly by a PSW. In a separate interview with RPN #106 they confirmed that resident #007 was the resident involved as they had indicated in the email they submitted.

Inspector #684 reviewed the email sent to the Chief Executive Officer (CEO) #100 and DOC #101 from RPN #106, the email indicated that resident #007 was the resident involved in the repositioning incident. [s. 104. (1) 2. i.]

Issued on this 29th day of January, 2020

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

Original report signed by the inspector.