Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: August 1, 2024

Inspection Number: 2024-1279-0004

Inspection Type:
Complaint
Critical Incident

Licensee: MacGowan Nursing Homes Ltd.

Long Term Care Home and City: Braemar Retirement Centre, Wingham

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 3-5, 8-11, 2024

The following intake(s) were inspected:
- Intake: #00117208 - Prevention of Abuse and Neglect
- Intake: #00117732 - Falls Prevention and Management
- Intake: #00119202 - complaint related to Falls Prevention and Management and Nutritional care.

The following **Inspection Protocols** were used during this inspection:

Food, Nutrition and Hydration

Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to protect a resident from abuse by another resident.

Rationale and Summary:

For the purposes of the definition of “abuse” “sexual abuse” means,

Any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff

A staff member witnessed a resident inappropriately touching a co-resident. They

immediately removed the co-resident from the area, taking them to their room and reported the incident to an RN.

Sources: Investigation notes, resident's progress notes, surveillance video, interview with staff members and DOC.

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance:

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, 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.

The licensee has failed to ensure the home's zero tolerance of abuse and neglect policy was followed after sexual abuse was witnessed and reported.

Rationale and Summary:

The Zero Tolerance of Abuse and Neglect policy dated January 2023, stated that if a staff member or volunteer becomes aware of or suspects potential or actual abuse or neglect of a resident, be it by a staff member, volunteer, family member, co-worker, student, or another resident the following steps must be taken.
Charge Nurse on duty:
1. Assess and evaluate injuries and document each shift for a minimum of 72 hours post incident,

2. Based upon the incident, determine if a more in-depth head to toe assessment is required,
3. Notify the family/representative/substitute decision maker of an instance of alleged abuse,
4. Obtain statements from all witnesses and document his/her account of the incident,
5. Remind witness of the need to maintain confidentiality of the incident as well as both the resident and the alleged abuser,
6. Notify Physician/Nurse Practitioner.

A resident was witnessed touching a co-resident inappropriately. The incident was reported to a charge nurse who failed to follow the home's zero tolerance of abuse and neglect policy.

The RN's failure to follow the abuse policy made it challenging to know the impact to the resident and what follow up was required.

Sources: Progress notes for residents, Zero Tolerance of Abuse and Neglect policy (revised January 2023), and interviews with RN and other staff.

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (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: 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.

The licensee failed to ensure that when staff had reasonable grounds to suspect resident to resident sexual abuse had occurred, that they immediately reported the suspicion and the information upon which it was based to the Director. Pursuant to s. 154 (3), the licensee was vicariously liable for staff members failing to comply with subsection 28 (1).

Rationale and Summary:

A staff member and witnessed a resident inappropriately touching a co-resident and reported the incident to an RN who failed to report the incident to the manager on duty.

The DOC received an email the next morning and reported the alleged abuse to the Director and started an investigation.

Failure to immediately report concerns delayed the home's response and increased the risk of a similar incident happening to another resident. The delayed reporting may have delayed the Director in responding to the incident.

Sources: CIS report, written warning for RN and, interviews with RN and DOC.

COMPLIANCE ORDER CO #001 Requirements on licensee before discharging a resident

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 161 (2)
Requirements on licensee before discharging a resident
s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried;
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident;
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that their wishes are taken into consideration; and
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee must be compliant with O. Reg. 246/22 s. 161 (2)

Specifically, the licensee must:

a) Ensure that the management team in the home and any other home staff responsible for discharging a resident, reviews the following provisions of O. Reg. 246/22: s. 161 (2) - Requirements on licensee before discharging a resident.

b) A documented record of the review of the legislation outlined in part a) and who

participated must be maintained.

c) Review and revise as needed the home's process to when discharging a resident from the long-term care home. Ensure the process for discharge is in compliance with and is implemented in accordance with all applicable requirements under the Act and Regulation. A documented record of the review and revision, the changes made if any, and who participated must be maintained.

Grounds

The licensee has failed to complete the appropriate requirements for a resident's discharge from the home.
Before discharging a resident under subsection 157 (1), the licensee was to ensure:

(a) that alternatives to discharge were considered and, where appropriate, tried,

(b) that the appropriate placement coordinator and other health service organizations, made alternative arrangements for the accommodation, care and secure environment required by the resident;

(c) that the resident and the resident's substitute decision-maker, if any, and any person either of them may direct was kept informed and given an opportunity to participate in the discharge planning and that their wishes were taken into consideration; and

(d) a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct was provided setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to

discharge the resident. O. Reg. 246/22, s. 161 (2).

Rationale and Summary:

An incident between two residents was investigated by both the DOC and the authorities, after which it was decided by the home to transfer one of the residents to the hospital. The progress notes stated that after the home spoke with the resident's physician, it was decided that the resident would not be returning to the home.

Prior to discharging the resident, the home did not follow the steps as outlined in Ontario Regulation 246/22 s. 161 (2).

The home failed to make appropriate arrangements for resident 's care and safety by informing them directly or including them in the discharge from the facility, and by not adhering to the proper discharge procedure. This had a significant negative impact on the resident's quality of life.

Sources: Progress notes for resident, interviews with resident, DOC, Administrator and Social Worker, discharge letter and investigation notes.

This order must be complied with by September 6, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.