Ontario

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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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
Apr 12, 2019	2019_779641_0007	005060-19, 006825-19	Critical Incident System

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue WOODSTOCK ON N4S 3V9

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

Caressant Care Marmora
58 Bursthall Street P.O. Box 429 MARMORA ON K0K 2M0

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

CATHI KERR (641)

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): April 5, 9, 10, 2019.

This inspection was conduction in relation to intake log #005060-19, CIS #2718-000010-19 and intake log #006825-19, CIS #2718-000011-19, related to alleged abuse or neglect of residents.

During the course of the inspection, the inspector(s) spoke with the Director of Care, Registered Nurses, Personal Support Workers, and residents.
During the course of the inspection, the Inspector reviewed resident care and services, staff to resident interactions, reviewed resident health care records and Critical Incident System reports (CIS) and relevant licensee investigation notes and policies and procedures related to Prevention of Abuse and Neglect.

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.
- **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. 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 failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

An inspection was conducted in relation to Intake Log #005060-19, CIS #2718-000010-19 related to alleged physical abuse of resident #001 by PSW #102.

Critical Incident #2718-000010-19 indicated that on a specified date, while PSW #102 was completing care on resident #001, the resident began to resist the PSW. PSW #102 restrained the resident in order to complete the care.

During an interview with Inspector #641 on April 10, 2019 at 1145 hours, PSW #101 indicated that on the evening of the incident, the PSW was assisting PSW #102 to do the resident's care. PSW #101 advised that resident #001 was resisting care so PSW #102 restrained the resident and continued to do the care. PSW #101 advised that routine practice when a resident was refusing or resisting care, was that the staff would leave the resident and come back later to see if they would then accept the care.

Inspector #641 was unable to interview PSW #102.

Inspector #641 reviewed resident #001's health care record including the resident's care plan. Resident #001's care plan identified that when the resident was resistive to treatment or care, the staff were to leave the resident and return in five to ten minutes.

During an interview with Inspector #641 on April 10, 2019 at 1410 hours, the Director of Care (DOC) advised that the expectation was that when a resident was resisting care, the staff would leave the resident and return later to complete care.

The licensee failed to ensure that the care set out in the plan of care for resident #001 was provided to the resident as specified in the plan. [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 the plan of care is provided to residents as specified in their plans, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect residents from abuse by anyone and to ensure that residents are not neglected by the licensee or staff.

An inspection was conducted with regards to Intake Log #005060-19, CIS #2718-000010 -19 related to alleged physical abuse of residents #001 and #002 by PSW #102.

Critical Incident #2718-000010-19 indicated that marks had been noted on resident #001 that had been unexplained. Through investigation of these marks, alleged physical abuse of two residents, #001 and #002, by PSW #102 was discovered. The critical incident documented that on a specified date, while PSW #102 was completing care on resident #001, the resident began to resist the PSW. PSW #102 restrained the resident in order to complete the care, causing marks. The critical incident identified an incident that had occurred months before, in which PSW #101 had heard PSW #102 slap resident #002's hand several times, and then observed PSW #102 attempt to slap resident #002's hand again later on the same shift.

Inspector #641 was unable to interview PSW #102.

Inspector #641 reviewed the licensee's investigative notes related to the incidents.

When interviewed by the licensee, PSW #102 acknowledged having slapped resident #002's hand and fingers a couple of times in the past. The notes indicated that initially PSW #102 acknowledged holding resident #001, but denied having restrained the resident. When asked again later, PSW #102 answered that "maybe I did … I wish I could remember."

During an interview with Inspector #641 on April 10, 2019 at 1145 hours, PSW #101 indicated that on the evening of the incident on the specified date, the PSW was assisting PSW #102 to do the resident's care. PSW #101 advised that resident #001 was resisting care so PSW #102 restrained the resident and continued to do the care. PSW #101 advised that routine practice when a resident was refusing or resisting care, was that the staff were supposed to leave the resident and return later to see if they would then accept the care.

PSW #101 indicated to the Inspector that months earlier, while doing care with PSW #103 on one resident, PSW #102 was doing care on resident #002 in the same room. They heard slapping on the other side of the curtain and realized that PSW #102 had slapped resident #002's hand several times. During the next round of care, PSW #101 was assisting PSW #102 with resident #002's care. PSW #102 attempted to slap the resident's hand, but PSW #101 put their hand in the way, so was slapped instead of the resident. PSW #101 advised that the slap had stung at the time. PSW #101 had told PSW #102 that slapping a resident was not acceptable.

During an interview with Inspector #641 on April 10, 2019 at 1410 hours, the DOC advised that what precipitated the investigation into these incidents was that staff had noted marks on resident #001 but didn't know how it had happened. Around that time, a PSW reported that they had heard that PSW #102 had caused the marks to resident #001. The DOC advised that while investigating this incident, they had become aware of the second incident that had occurred several months earlier with resident #002.

The DOC indicated that PSW #102 continued to work with resident #002 after allegedly slapping the resident, until the investigation into the incident with resident #001 months later. The DOC advised that PSW #102 was now no longer working with either resident #001 or #002.

The licensee failed to protect residents #001 and #002 from PSW #102. [s. 19. (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 protect residents from abuse by anyone and to ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: 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 failed to 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.

An inspection was conducted with regards to Intake Log #005060-19, CIS #2718-000010 -19 related to alleged physical abuse of residents #001 and #002 by PSW #102.

Critical Incident #2718-000010-19 indicated that marks had been noted on resident #001 that had been unexplained. Through investigation of these marks, alleged physical abuse of two residents, #001 and #002, by PSW #102 was discovered.

The critical incident indicated that when interviewed, PSW #101 advised that on a specified date, while PSW #102 was completing care on resident #001, the resident began to resist the PSW. PSW #102 restrained the resident in order to complete the care. During the interview, PSW #101 indicated having witnessed PSW #102 slapping another resident months prior to this. The critical incident specified that PSW #101 had reported both incidents to the RNs on duty at the time, but none of the registered nursing

staff had been aware of the incidents.

Inspector #641 reviewed the licensee's critical incident investigation notes related to the incident. The notes indicated that both PSW #101 and PSW #103 had witnessed the inappropriate treatment of residents by PSW #102 that occurred on two occasions, but the incidents had not been reported to a manager. The investigative notes indicated that both PSW #101 and #103 had been disciplined for not reporting the two incidents immediately.

The Inspector reviewed the licensee's Abuse and Neglect policy – Staff to Resident, Family to Resident, Resident to Resident, Resident and /or Family to Staff, effective date August, 2018 and last reviewed date September 2018. On page 4 under Reporting, the policy stated: All cases of suspected or actual abuse must be reported immediately to the DOC/Executive Director. In the absence of management staff, concerns should be reported immediately to the Charge Nurse, who will notify management staff on call.

During an interview with the Inspector on April 10, 2019, at 1410 hours, when asked about why the PSWs had not reported the incidents to the DOC immediately, the DOC advised that PSW #101 had been reluctant to come forward due to possible retaliation from PSW #102. The DOC indicated being aware that the staff were to report any suspicion of abuse to their superior immediately, who would then let management staff on call know.

The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with by PSWs #101 and #103. [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 that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and to ensure that the policy is complied with, to be implemented voluntarily.

WN #4: 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 failed to ensure that a person who has reasonable grounds to suspect that 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, shall immediately report the suspicion and the information upon which it is based to the Director.

An inspection was conducted with regards to Intake Log #006825-19, CIS #2718-000011 -19, related to alleged verbal abuse and neglect by staff to resident #003. Resident #003 had alleged being left without care for two hours and being spoken to inappropriately three times by RN #105; and Intake Log #005060-19, CIS #2718-000010-19 related to alleged physical abuse of residents #001 and #002 by PSW #102.

Critical incident #2718-000011-19 indicated that the incident had occurred on a specified date and that it had been reported to the Director of Care (DOC) by the resident two days later. The critical incident was submitted to the Director five days after the incident and three days after the resident had report it to the DOC.

During an interview with Inspector #641 on April 10, 2019 at 1135 hours, RN #105 indicated having written up an account of the incident on the weekend that the incident had occurred and having left this for the DOC, who would have received the written account two days after the incident occurred.

During an interview with Inspector #641 on April 10, 2019 at 1410 hours, when asked about the time line for submitting the critical incident to the Director, the DOC advised being unaware of the requirement to submit the critical incident immediately. The DOC advised having waited until the investigation had been completed before submitting the report to the Director.

Critical incident #2718-000010-19 indicated PSW #101 advised that on a specified date, while PSW #102 was completing care on resident #001, the resident began to resist the PSW. PSW #102 restrained the resident in order to complete the care. During the interview, PSW #101 indicated having witnessed PSW #102 slapping another resident months prior to this. The critical incident specified that PSW #101 had reported both incidents to the RNs on duty at the time, but none of the registered nursing staff had been aware of the incidents and none of the management staff had been informed.

During an interview with Inspector #641 on April 10, 2019 at 1145 hours, PSW #101 indicated reporting what PSW #102 had done to resident #001 on the specified date, to the RN on duty and one other PSW. With respect to the incident that had occurred months earlier with resident #002, PSW #101 advised having told the RN that night about the incident but couldn't remember who that was. When asked by the Inspector about not reporting these incidents to a manager, PSW #101 expressed concerns about what PSW #102 might do, as why they had not spoken to anyone else about either incident.

During an interview with the Inspector on April 10, 2019, at 1410 hours, the Director of Care (DOC) indicated that when asked about why the PSWs had not reported the incidents to the DOC immediately, the DOC advised that PSW #101 had been reluctant to come forward due to possible retaliation from PSW #102. The DOC indicated being aware that the staff were to report any suspicion of abuse to their superior immediately, who would then let management staff on call know.

The licensee failed to ensure that when the licensee had a suspicion of abuse and neglect of resident #001, #002 and #003, the licensee had not immediately reported the suspicion and the information upon which it was based, to the Director. [s. 24. (1)]

Issued on this 1st day of May, 2019

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

Original report signed by the inspector.