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

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
Jun 18, 2019	2019_779641_0012	008270-18, 016206-18, 025988-18, 026492-18, 000382-19, 001481-19, 005265-19	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the County of Northumberland
983 Burnham Street COBOURG ON K9A 5J6

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

Golden Plough Lodge
983 Burnham Street COBOURG ON K9A 5J6

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

CATHI KERR (641), DARLENE MURPHY (103)

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): May 28, 29, 30, 31, June 3, 4, 5, and 6, 2019.

This inspection was conducted in reference to the following intake logs: Log #005265-19, CIS #M531-000008-19, Log #001481-19, CIS #M531-000004-19 and Log #025988-18, CIS #M531-000017-18 related to alleged resident abuse; Log #026492-18, CIS #M531-000019-18 and Log #016206-18, CIS #M531-000012-18 related to residents having fallen resulting in an injury; Log #000382-19, CIS #M531-000002-19 related to an injury to a resident; and Log #008270-18, CIS #M531-000005-18 related to a respiratory outbreak.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Associate Director of Cares (ADOC), the Care Coordinator (CC), Registered Nurses (RN), Registered Practical Nurses (RPN), Behavioural Support Nurses (BSO), Personal Support Workers (PSW) and residents.
During the course of the inspection, the Inspectors observed resident care and services, staff to resident and resident to resident interactions, reviewed resident health care records and Critical Incident System reports (CIS) and relevant licensee investigation notes, relevant policies related to zero tolerance of abuse and falls prevention.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 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. 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 has failed to ensure the written policy to promote zero tolerance of abuse of residents was complied with.

The home submitted a critical incident (M531-000017-18) to report an alleged resident sexual abuse on a specified date.

According to the Ontario Regulation 79/10, s. 2 (1), sexual abuse is defined as follows: any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or 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 member.

PSW #107 was interviewed and stated on the evening of a specified date, resident #003 appeared visibly upset. PSW #107 stated resident #003 reported a resident had entered their room two nights ago and had attempted to lie on top of them and engage in sex. The PSW #107 stated resident #003 believed the person may have been a staff member. PSW #107 stated they immediately reported the allegation to RPN #115 and was told by RPN #115 they knew resident #003 well and the resident was confused. According to PSW #107, no further action was taken at that time.

RPN #115 was interviewed and indicated they recalled the incident. RPN #115 stated resident #003 had responsive behaviours and at the time of the alleged incident, they believed the allegation was unfounded because none of the residents on the unit would have been physically capable of doing what resident #003 was describing. RPN #115 stated they contacted the behavioural support worker, RPN #105 to report resident #003's increase in confusion.

RPN #105 was interviewed and stated they recalled discussing the incident with RPN

#115, but did not speak with resident #003. RPN #105 stated they believed the allegation was behavioural and indicated resident #003 had previously accused a former room-mate of a physical abuse. RPN #105 stated they did not document the incident and did not report the allegation to anyone.

ADOC #108 was interviewed and stated they became aware of resident #003's allegation during a review of the twenty-four hour notes on the morning after the specified date. ADOC #108 indicated they noted the night shift RPN #117 had documented resident #003 was more confused than their normal and had reported a resident was entering their room at night. ADOC #108 indicated at that time, they began to investigate and reported the alleged incident to the MOHLTC, the police and resident #003's Power of Attorney.

The licensee's abuse policy, "Prevention, Reporting and Elimination of Resident Abuse", dated September 2016 was reviewed. The policy on page 3/18 states: all staff are required to comply with the guidelines for the prevention of resident abuse and the reporting of suspected resident abuse. Golden Plough Lodge expects that staff immediately report every alleged, suspected or witnessed incident of abuse. Every reported incident of abuse of a resident is reported to the Ministry of Health and Long Term Care immediately.

On page 4/18, the policy states: staff must report the matter without delay to their immediate supervisor and the Director of Care, or designate who must then immediately forward notification to the Administrator. The resident's substitute decision maker shall be immediately notified upon the home becoming aware of the abuse or suspected abuse which causes distress to the resident. Additionally, the home shall ensure the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse of a resident.

According to ADOC #108, RPN #105, #115 and #117 failed to report the alleged incident of resident sexual abuse because they made the determination that the incident was the result of resident #003 behaviours and failed to follow the abuse policy. ADOC #108 stated the expectation is to report as outlined in the abuse policy such that an immediate investigation can be completed to ensure residents are protected from abuse. ADOC #108 stated upon the completion of the home's investigation, it was determined the allegation was unfounded.

The licensee failed to ensure staff complied with the licensee's abuse policy. [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 their written policy to promote zero tolerance of abuse and neglect of residents is complied with, 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. A person who had resasonable grounds to suspect the abuse of a resident failed to immediately report the suspicion and the information upon which it was based to the Director (MOHLTC).

As outlined in WN #1, resident #003 reported to PSW #107 on the evening of a specified date, they had allegedly been sexually abuse by a staff. In an interview with ADOC #108, they indicated the Director (MOHLTC) was notified of the alleged abuse for the first time by means of the critical incident which was submitted a day later.

The home failed to immediately report an alleged sexual abuse immediately to the Director. [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 had reasonable grounds to suspect the abuse of a resident immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #3: 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 failed to ensure resident #003's substitute decision maker (SDM) was immediately notified of an alleged incident of abuse that caused distress to resident #003.

As outlined in WN #1, resident #003 reported an alleged incident of sexual abuse to PSW #107 on the evening of a specified date. According to PSW #107, resident #003 was upset at that time. Resident #003's SDM was not notified of the alleged incident of sexual abuse until the next day. [s. 97. (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 the resident's substitute decision-maker are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure the appropriate police force were immediately notified of resident #003's alleged incident of sexual abuse.

As outlined in WN #1, the police were notified of resident #003's alleged incident of sexual abuse for the first time on a specified date by ADOC #108, not immediately as outlined in the legislation. [s. 98.]

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 appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #5: 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. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the results of resident #003's abuse investigation was reported to the Director.

As outlined in WN #1, the home submitted a critical incident (M531-000017-18) to report an alleged resident sexual abuse involving resident #003 on a specified date. The incident report indicated results of testing were still pending, safety monitor to be installed and staff were continuing to monitor closely. To date of this inspection, there were no amendments made to the incident report and the critical incident failed to outline the results of the abuse investigation. [s. 23. (2)]

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Issued on this 25th day of June, 2019

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

Original report signed by the inspector.