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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 15, 2015	2015_285546_0011	O-001975-15	Critical Incident System

Licensee/Titulaire de permis

HILLTOP MANOR NURSING HOME LIMITED
82 Colonel By Crescent Smiths Falls ON K7A 5B6

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

HILLTOP MANOR NURSING HOME LIMITED
1005 ST LAWRENCE STREET P.O. BOX 430 MERRICKVILLE ON K0G 1N0

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

SUSAN WENDT (546)

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 21 and 22, 2015

For Log # O-001975-15

During the course of the inspection, the inspector(s) spoke with the Associate Director of Care (ADOC), the RAI Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Worker (PSW) and the Business Office Manager. The inspector also reviewed CIR 2645-000004-15, residents' health records, plans of care, medication and treatment administration records, progress notes, PIECES Assessment worksheets, Behavioural Support Services documentation, the Responsive Behavior Program, the Zero Tolerance Policy and Procedure, in addition to Policies and Procedures related to Resident to Resident Assaults, Critical Incidents and After Hours Notification - Operations.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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	Legendé 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. 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, with reasonable grounds to suspect abuse of a resident by another resident of the Home, immediately reported the suspicion and the information which it was based to the Director.

A resident sustained an upper arm injury following a fall on an evening in April 2015, when the resident alleged being shoved by a co-resident, who was standing in the room at the time of discovery. The injured resident was not sent to hospital, but was treated conservatively by a physician in the long term care home.

Documentation of the incident indicated that although the fall incident was unwitnessed by staff, it was possible resident to resident abuse. It was reported during the morning report to the ADOC.

A Critical Incident Report was submitted in April 2015 by the Home's ADOC.

In an interview with the Inspector on a specific day in May 2015, the ADOC indicated that she was waiting to see a significant change in the injured resident before submitting the report. The ADOC was unaware that a person, with reasonable grounds to suspect abuse of a resident, had to report the suspicion and the information immediately. The ADOC believed the Home had 10 days to complete and remit the report. [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 revision of the Home’s Residents / Resident Assaults and Critical Incidents policies and procedures are completed ensuring that it includes within the policy an explanation of the duty to make under section 24 of the Long Term Care Homes Act mandatory reports. The policy revision must ensure that a person, inclusive of a staff member has a duty to report to the Director irrespective of the Licensee's duty, that staff members must report any incident or suspected incident of resident abuse or neglect to the Director, that a person including a staff member must report suspicion of abuse or neglect of a resident that resulted in harm or risk of harm including the information upon which the suspicion is based where the person has reasonable grounds for the suspicion and where the duty to report to the Director is immediate. This plan should include an educational component ensuring that all staff receive this information in respect to the aforementioned legislation, to be implemented voluntarily.

WN #2: 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 that the appropriate police force was immediately notified of the suspected incident of abuse of a resident by another resident of the Home.

A resident sustained an upper arm injury following a fall on an evening in April 2015, when the resident alleged being shoved by a co-resident, who was standing in the room at the time of discovery.

Documentation of the incident indicated that although it was unwitnessed by staff, it was possible resident to resident abuse. It was reported during the morning report to the ADOC. A Critical Incident Report (CIR) was filled and submitted in April 2015 by the Home's ADOC; the CIR did not indicate any reports to the appropriate police force for suspicion of abuse.

In an interview with the Inspector on a specific day in May 2015, the ADOC indicated not being aware she had to contact the appropriate police force to report the suspicion of abuse of a resident by another resident. [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 a revision of the Home's Residents / Resident Assaults and Critical Incidents policies and procedures are completed ensuring that it includes within the policy an explanation of the duty to make under section 24 of the Long Term Care Homes Act mandatory reports. The policy revision must ensure that a person, inclusive of a staff member has a duty to report to the Director irrespective of the Licensee's duty, that staff members must report any incident or suspected incident of resident abuse or neglect to the Director, that a person including a staff member must report suspicion of abuse or neglect of a resident that resulted in harm or risk of harm including the information upon which the suspicion is based where the person has reasonable grounds for the suspicion and where the duty to report to the Director is immediate. In addition, 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. This plan should include an educational component ensuring that all staff receive this information in respect to the aforementioned legislation, 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 its policy and procedure to promote zero tolerance for abuse and neglect of residents was complied with.

The Home's policy and procedure for Resident to Resident Assaults, numbered as E-40

with a revised date of May 19, 2015, clearly indicated the procedure for assessing and intervening when there is a resident to resident assault.

Point 5 of said policy clearly indicated the following: In instances where there is a resident to resident assault, a critical incident report must be completed. Refer to the Critical incident System policy.

In addition to the aforementioned, Point 6 (g) of the E-40 policy indicated: Notify the Director of Care and/or Administrator. The Director of Care and/or Administrator will determine if the Police needs to be notified.; Point 6 (h) further indicated Notify the Ministry of Health Long Term Care (MOHLTC) of the critical incident.

The Home's policy and procedure for Critical Incidents, numbered as E-45 with a revised date of March 22, 2015, clearly indicated under Point 3 of the Standard: All critical incidents must be documented and reported to the Ministry of Health LTC Centralized Intake Assessment Triage Team (CIATT). The procedure further states under Point 1 that all critical incidents, which pose a risk to residents, are to be reported to the Director of Care/Associate Director of Care immediately… Such incidents shall include, but not limited to: a) alleged or actual abuse/assault involving resident. Point 3 of the procedure clearly identified LTCHA, Subsection 24(1) – Reporting Certain Matters to the Director: A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately [bold] report the suspicion and the information upon which is based to the Director. It further indicated, After hours, please use the MOHLTC's emergency contact.

On an evening in April 2015, a resident sustained an upper arm injury following a fall whereby the resident alleged being shoved by co-resident, who was standing in the room at the time of discovery. Registered staff intervened in providing immediate care to the injured resident and by removing the other resident from the room, however, the MOHLTC was not immediately notified by anyone from the Home.

A Critical Incident Report (CIR) was submitted in April 2015 by the Home's ADOC.

In an interview with the Inspector on a specific day in May 2015, the ADOC indicated that she was waiting to see a significant change in the injured resident before submitting the report. Despite the clear indication in the Home's policy, the ADOC was unaware that a person, with reasonable grounds to suspect abuse of a resident, had to report the suspicion and the information immediately. [s. 20. (1)]

Issued on this 15th day of June, 2015

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

Original report signed by the inspector.