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 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 sions de longue durée

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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
Apr 12, 2016	2016_393606_0004	019322-15	Critical Incident System

Licensee/Titulaire de permis

IOOF SENIORS HOMES INC.
20 Brooks Street BARRIE ON L4N 5L3

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

ODD FELLOW AND REBEKAH HOME
10 BROOKS STREET BARRIE ON L4N 5L3

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

JANET GROUX (606)

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): February 9, 10, 11, and 12, 2016.

During the course of the inspection, the inspector(s) spoke with the Administrator/CEO, Director of Resident Care (DRC), the Assitant Director of Resident Care (A)DRC, Nurse Managers (NM), Director of Human Resources, Nurse Practitioner (NP), Registered Nurses (RN), Registered Practical Nurses (RPN), Placement Students, Residents, and Substitute Decision Makers (SDM).

During the course of the inspection, the inspector conducted observation of residents and home areas, staff to resident interactions, reviewed clinical health records, and relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **6 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	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. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff received training on the home's policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities.

Review of a critical incident (CI) report on an identified date revealed an allegation of sexual abuse.

Interviews and record reviews revealed the alleged staff member was identified as a placement student in the home during the time of the alleged incident.

Review of an identified home policy indicated the home provides annual mandatory educational in services to employees and volunteers regarding abuse and neglect. Further review of the home's training records for the student placements revealed two identified students had no records to indicate they had received their training and education.

Interview with a manager revealed the home has assigned the placement college the responsibility to provide their students with the training and education on the home's abuse/neglect policy.

Interviews with the two identified students confirmed their college did not provide them training and education on the home's policy.

Interview with the college student instructor confirmed he/she did not provide training to the students mentioned above. [s. 76. (2) 3.]

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 receive training on the home's policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

Review of a CI on an identified date indicated an allegation of sexual abuse.

Review of an identified home policy titled stated the home is to "maintain complete written records of all meetings/conversations".

Review of the home investigation documents failed to locate records of interviews, updates from police and the outcome of the police investigation.

Interview with the (A)DRC revealed he/she is unable to provide the outcome of the police investigation with the placement student because he/she did not document the information. The (A)DRC confirmed it is the home's policy to document and keep records of all investigations and confirmed the above information was not documented. [s. 8. (1) (b)]

WN #3: 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 report to the Director the results of the investigation.

Review of a CI on an identified date was last amended on an identified date did not contain the outcome of the abuse investigation. There were no amendment made to the CI after this date.

Interview with the DRC revealed the CI was last updated on an identified date and indicated the investigation was still pending at this time. [s. 23. (2)]

WN #4: 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. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident and the resident's substitute decision-maker, if any, was notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

Review of a CI report on an identified date indicated an allegation of sexual abuse.

Interview with resident #001's SDM revealed the home informed him/her on an identified date during a meeting that the home had interviewed the placement student and had concluded that the incident was a misunderstanding and did not tell the SDM that the student was not yet been interviewed by the police.

Interview with the police officer who was involved in assisting the home with the investigation revealed he/she did not interview the placement student until late on an identified date and confirmed that there was no evidence of sexual abuse as reported.

Review of the home's investigation documents revealed the home notified resident #001's SDM on an identified date, and informed him/her that the home had completed an interview with the alleged care provider identified as a placement student and had concluded from this interview the incident was a misunderstanding and did not inform the SDM the police investigation was still in progress. The placement student was reinstated back to the home on an identified date.

Interview with the (A)DRC confirmed the home did not provide the SDM the information that the student had not been interviewed and that the investigation was still in progress. [s. 97. (2)]

WN #5: 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 that the appropriate police force was 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.

Review of a CI report on an identified date indicated an allegation of sexual abuse.

Interview and record review revealed the police were notified on an identified date two days after the allegation was reported by resident #001 to the Home.

Interview with resident #001 revealed he/she reported to RPN #100 that an identified man came to his room and sexually abused him/her.

Interview with the RPN #100 and the (A)DRC revealed the home was investigating the incident as an alleged sexual abuse and confirmed the police was not notified immediately. [s. 98.]

WN #6: 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 the report to the Director included the names of any staff members or other persons who were present at or discovered the incident.

Review of a CI on an identified date did not include the name of the staff member reported in the alleged staff to resident sexual abuse reported by resident #001.

Interview with the ADRC revealed the alleged care provider was identified as a placement student but his/her name was not included in the CI report to the Director due to confidentiality. [s. 104. (1) 2.]

Issued on this 24th day of May, 2016

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

Original report signed by the inspector.