Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
Nov 8, 2019	2019_771609_0018	015394-19, 015848-19, 015934-19, 016939-19, 018904-19, 018986-19, 019538-19, 020367-19, 020641-19	Critical Incident System

Licensee/Titulaire de permis

Orillia Long Term Care Centre Inc.
c/o Jarlette Health Services 711 Yonge Street MIDLAND ON L4R 2E1

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

Leacock Care Centre
25 Museum Drive ORILLIA ON L3V 7T9

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

CHAD CAMPS (609), JENNIFER NICHOLLS (691), MICHELLE BERARDI (679)

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): October 21-25, 2019. Additional off-site activities were conducted on October 28, 2019.

The following intakes were inspected upon during this Critical Incident System (CIS) Inspection:

Five Intakes related to abuse of residents;

Two Intakes related to responsive behaviours of a resident;

One Intake related to a fall of a resident; and

One Intake related to a medication incident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Directors of Care (Co-DOCs), Resident Care Services Coordinator (RCSC), Administrative Assistant (AA), Scheduler, Regional Environmental Services Manager, Environmental Services Manager (ESM), Restorative Care Coordinator (RCC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Life Enrichment Aides (LEAs), residents and family members.

The Inspector(s) also observed resident care areas, the provision of care and services to residents, resident to resident interactions, reviewed relevant health care records, internal investigation documents, policies, procedures and training records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

8 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 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 that where the Act or the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy or procedure, that the plan, policy or procedure was complied with.

Specifically, the licensee had failed to comply with their policy titled ""“Resident Rights, Care and Services – Medication Management – Narcotics and Controlled Substances” last revised May 28, 2019, which was part of the home's medication management system's written policies and procedures.

Inspector #609 reviewed the home’s policy titled “Resident Rights, Care and Services – Medication Management – Narcotics and Controlled Substances” last revised May 28, 2019, which required registered staff maintain keys to narcotics on their person and required two registered staff document a complete count together of all narcotics whenever an exchange of medication keys took place.

A Critical Incident (CI) report was submitted by the home to the Director which outlined how a tablet of resident #018’s controlled substances went missing and was never found.

A review of the home’s internal investigation found that Registered Nurse (RN) #124 gave the keys to the medication room (which included the keys to the locked medication cart as well as locked controlled substances box) to Registered Practical Nurse (RPN) #135. The RPN asked for the keys in order to clean up the room and do vitals. RPN #135

was alone in the medication room for approximately 5-10 minutes, after the evening controlled substances count had already been completed (by RPN #135 and RN #124) with no discrepancies.

When RN #124 realized that they had accidentally given the keys to the locked medication cart and locked controlled substances box along with the medication room keys to RPN #135, they performed a controlled substances count with another registered staff member and found a tablet of resident #018's controlled substances was missing.

During an interview with RN #124, they described how they gave their medication room keys to RPN #135. The RN indicated that they did not realize they gave both the medication room and controlled substances keys to the RPN.

RN #124 indicated that when they realized their error later in their shift, they performed a controlled substances count with another registered staff member and noted a tablet of resident #018's controlled substances was missing.

RPN #135 was unavailable for an interview during the inspection.

During an interview with the Administrator, they indicated that at times the medication keys would be shared between registered staff members in order to complete tasks, but that any switch of the controlled substances keys meant a count of the controlled substances was redone. The Administrator indicated that RN #124 and RPN #135 would be retrained on the home's narcotics policy and due to the severity of what happened would also receive discipline. [s. 8. (1) (b)]

2. Specifically, the licensee had failed to comply with their policy titled "Code White- Violent Situation" last revised September 10, 2019, which was part of the home's emergency plans.

Inspector #679 reviewed the policy titled "Code White- Violent Situation" last revised on September 10, 2019. The policy identified the following under the procedure section: If a violent situation that cannot be controlled requires assistance from another employee: keep a safe distance, provide a safe environment for others, using the overhead page system announce Code White three times along with the location, call 911 if the situation continues to escalate and keep residents calm.

A CI report was submitted by the home to the Director which outlined how resident #004

demonstrated responsive behaviours that continued to escalate causing injuries to staff and residents. Interventions were attempted, however the resident continued to demonstrate responsive behaviours. Code White was called long after the incident began.

Inspector #679 reviewed the home's internal investigation of the incident and found a note which indicated "Code White not called", "[staff] present and did not call a Code White" and "Code White needs to be reviewed by all staff". An additional document titled "Employee Incident Report" indicated "education of staff [regarding] Code White" under the section hazard control measures to prevent a similar accident.

In an interview with Personal Support Worker (PSW) #134, they recalled the incident from the CI report and stated "I believe [PSW #113] and I told the Nurse to call the Code White. The Code White wasn't called for some reason, but a Code White was called sometime after".

In an interview with Inspector #679, RN #118 identified that they had responded to the incident involving resident #004. RN #118 identified that they had asked several times for the staff to call a Code White. RN #118 further identified that the Code White was called long after they had first requested it from staff.

RN #118 identified that the home's policy was that when a resident became aggressive and could not be redirected, then staff were to call the Code White which did not occur within a "reasonable amount of time".

In an interview with Co-Director of Care (Co-DOC) #105, they identified that the home's process for initiating a Code White would be for staff to provide any interventions recommended in the resident's care plan, and if they weren't having success to call a Code White immediately.

In an interview with the Director of Care (DOC), they identified that a Code White would be initiated when a resident became aggressive and the interventions for their responsive behaviours were ineffective. (679) [s. 8. (1) (b)]

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 where the Act or the Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy or procedure, that the plan, policy or procedure is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways and to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to were kept closed and locked.

A CI report was submitted to the Director, for a resident who had eloped from the home through a stairwell when the maglocks were turned off during a power disruption.

In separate interviews with PSWs #116, #117, #126 and #127, they all indicated to Inspector #691, that they were aware of emergency procedures in the home related to a power disruption, including procedures to reset the maglocks. In an interview with RN #118 and RPN #125, they further indicated that once power had been restored, the RN was to announce, “all clear, and staff to reset maglocks”. RN #118 further indicated to Inspector #691 that there was a separate box to reset the maglocks for a specific home area and it was identified that some staff may not know where to do the reset. RN #118 indicated that any staff could reset the maglocks, and there was no designated procedure for this.

In a review of the homes policy, titled "Loss of Essential Services-Power Outage", last revised September 10, 2019, indicated "the charge nurse or designate [were to] utilize the power failure checklist to ensure all appropriate measures [were] taken". In a review of the "Power Failure Checklist", last revised August 9, 2019, indicated "when power [was] restored, designated Charge Nurse to ensure maglocks/door [were] operational (check all)".

In an interview with Regional Environmental Services Manager #128, they stated to Inspector #691 that on the day of the CI report, there was a power disruption in the building, in which the maglocks would be released and the doors unlocked. They further indicated that Environmental Services Manager (ESM) #137 completed the daily walk through of the home on the identified date after the power outage and prior to the resident elopement, as per the home's policy. Together with Inspector#691, Regional Environmental Services Manager #128 reviewed the audits from at the time of the CI report, indicating the maglocks and doors were checked post power failure and signed off by ESM #137 as completed. They further indicated that after the home’s investigation, they indicated that there was no malfunction of the maglock system, that they were not reset, and should have been. They further indicated that ESM #137 did not complete the maglock/door checks as indicated on the audits.

In an interview with Inspector #691, Resident Care Services Coordinator (RCSC) identified that during their investigation, resident #001 must have eloped from the home down the stairs after the maglocks were not reset. They identified that during the time from the power disruption until resident #001 eloped, the staff did not reset the maglocks and the doors were not checked to ensure they were secure, which should have occurred. They further identified that the home staff were all trained on power disruption procedures, which included to reset maglocks, ensure doors were locked, as well to ensure a power disruption checklist was completed, which did not occur. [s. 9. (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 all doors leading to stairways and to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to are kept closed and locked, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #020's plan of care was based on, at a minimum an interdisciplinary assessment of the following with respect to the resident: risk of falls.

Inspector #679 reviewed a fall incident report for resident #020, which identified that they had sustained an unwitnessed fall.

Inspector #679 reviewed the resident's electronic care plan and was unable to locate a focus related to the resident's risk for falls. A review of the resolved items of the care plan indicated that the resident's previous fall focus was resolved from the care plan prior to the fall from the CI report.

Inspector #679 reviewed resident #020's electronic progress notes and identified that they had sustained numerous falls previously.

In an interview with PSW #131, they identified that they would reference a resident's Kardex to determine if a resident was at risk for falls and any interventions in place to manage their risk for falls. PSW #131 identified that resident #020 had fallen, and that there were interventions in place to manage their risk for falls.

In an interview with RN #132, they identified that they would reference a resident's care plan to determine if a resident was at risk for falls and any interventions in place to manage their risk for falls. RN #132 confirmed that resident #020 was at risk for falls.

In an interview with the DOC, they identified that registered staff would reference a resident's care plan, and PSW staff would reference a resident's Kardex to determine if a resident was at risk for falls and any interventions in place to manage their risk for falls. The DOC identified that resident #020 was at risk for falls. Together, Inspector#679 and the DOC reviewed resident #020's electronic care plan. The DOC identified that resident #020's falls care plan had been resolved previously and that they had reactivated it. [s. 26. (3) 10.]

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 all residents' plans of care are based on, at a minimum, interdisciplinary assessment of their risk for falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #017 and #020 fell, that they were assessed and that where the condition of the residents required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A CI report was submitted to the Director for an incident that caused injury to a resident for which the resident was taken to hospital and which resulted in a significant change. The CI report identified that resident #017 had an unwitnessed fall; resident #017 was later transferred to hospital and diagnosed with an injury.

A) Inspector #679 reviewed resident #017's electronic progress notes regarding their fall and identified that the resident required a specific intervention that RPN #133 documented as "not applicable".

RPN #133 was unavailable for an interview during the inspection.

In an interview with RPN #125, they identified that the specified intervention was initiated for any unwitnessed falls.

In an interview with Co-Director of Care (Co-DOC) #102, they identified that the specified intervention would be initiated if a resident fell. Co-DOC #102 confirmed that staff did not initiate the specified intervention for resident #017.

B) Inspector #679 reviewed a fall incident report for resident #020, which identified that they had sustained an unwitnessed fall.

Inspector #679 reviewed resident #020's electronic progress notes regarding their fall and identified that RN #114 documented "not needed" for the specified intervention required for the resident.

In an interview with RPN #125, they identified that the specified intervention was initiated for any unwitnessed falls.

In an interview with the DOC, they identified that the specified intervention would be started after an unwitnessed fall. Together, Inspector#679 and the DOC reviewed resident #020's electronic progress notes regarding resident #020's fall. The DOC identified that from what they read, the specified intervention should have been started. [s. 49. (2)]

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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the right of residents to form relationships was fully respected and promoted.

A CI report was submitted by the home to the Director which described allegations of abuse between resident #007 and #008.

The CI report outlined how the residents were assessed by the home's Physician's Assistant (PA) #136 who did not classify the incident as abuse and provided staff with specific interventions to follow.

A) Inspector #609 observed resident #007 and #008 appeared to be enjoying one another's company.

A review of resident #007's plan of care found no indication of the specified interventions, while the interventions listed in the care plan, contradicted the PA's specified interventions.

During an interview with PSW #119, they described how they provided the opposite care to resident #007 and #008 than outlined by the PA.

During an interview with RPN #120, they described that because of resident #007's diagnosis they provided the opposite care than that outlined by the PA.

B) A review of resident #008's plan of care found no indication of the specified interventions until weeks after the incident.

During an interview with the Administrator and Co-DOC #105, they both verified that resident #007 and #008 had the right to form relationships, that staff were to follow the specified interventions and that their care plans were being updated to reflect this. [s. 3. (1) 18.]

WN #6: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for resident #017 that set out the planned care for the resident.

A CI report was submitted to the Director for an incident that caused injury to a resident for which the resident was taken to hospital and which resulted in a significant change. The CI report identified that resident #017 had an unwitnessed fall; was later transferred to hospital and diagnosed with an injury.

A) Inspector #679 reviewed resident #017's post-fall assessment which indicated that the resident specific intervention A at the time of the fall.

Inspector #679 reviewed resident #017's all electronic progress notes and care plans since the time of the incident and was unable to identify documentation to indicate that the resident had specified intervention A.

B) On a particular day, Inspector #679 observed resident #017 with specific intervention B in place.

Inspector #679 reviewed the electronic progress notes for resident #017 and identified that after the fall the resident had specified intervention B.

Inspector #679 reviewed resident #017's electronic care plan and did not find specified intervention B was identified in the care plan.

Inspector #679 reviewed the home's policy titled "Resident Rights Care and Services-Plan of Care" last revised September 24, 2019, which identified that there shall be a written plan of care for each resident that set out the planned care for the resident, the goals the care was intended to achieve and clear direction to staff and others who provided direct care to the resident.

In an interview with Inspector #679, PSW #126 identified that they would refer to a resident's care plan to determine if a resident was at risk for falls and any interventions in place to manage their risk for falls. PSW #126 identified that resident #017 was at risk for falls, and that they had specified intervention B in place. Together, Inspector#679 and PSW #126 reviewed the electronic care plan. PSW #126 identified that they did not see specified intervention B outlined in the care plan.

In an interview with Inspector #679, RPN #125 identified that staff would refer to a resident's care plan to determine if a resident was at risk for falls, and any interventions in place to manage the risk for falls. RPN #125 identified that resident #017 was at risk for falls, and that they had specified interventions B and C in place. Together, Inspector #679 and RPN #125 reviewed the electronic care plan. RPN #125 indicated they did not see specified interventions B or C in the care plan. RPN #125 confirmed that these interventions should be listed in the care plan.

In an interview with the Restorative Care Coordinator (RCC), they identified that fall prevention interventions would be identified in the resident's care plan. The RCC identified that resident #017 had specified intervention B for falls. The RCC indicated that specified intervention B was not listed in the resident's care plan.

In an interview with Co-DOC #102, they identified that staff would reference a resident's care plan or Kardex to determine a resident's fall prevention interventions. Co-DOC #102 indicated that resident #017 had specified interventions for falls and that they should have been added to a resident's care plan in a timely manner. [s. 6. (1) (a)]

2. The licensee has failed to ensure that resident #002's plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed, or care set out in the plan was no longer necessary.

A CI report was submitted to the Director for an incident of sexual abuse between resident #002 and #003.

Inspector #679 reviewed resident #002's electronic care plan and identified specific interventions at all times for the resident.

On a particular day, Inspector #679 observed resident #002 without the specified intervention in place.

In an interview with Inspector #679, PSW #108 identified that the specified intervention was not in place.

Inspector #679 reviewed the home's policy titled "Resident Rights Care and Services-Plan of Care" last revised September 24, 2019, which identified that there would be a written plan of care for each resident that set out the planned care for the resident, the goals the care was intended to achieve and clear directions to staff and others who provided direct care to the resident. The policy further identified that the plan of care would be reviewed and revised when the resident's care needs changed, the care set out in the plan was no longer necessary; or the care set out in the plan of care had not been effective.

In an interview with RN #114, they identified that resident #002 had the specified intervention in place, but that it was discontinued. Together, Inspector #679 and RN #114 reviewed resident #002's electronic care plan. RN #114 indicated that the specified intervention was still listed in the resident's care plan.

In an interview with Co-DOC #105, they identified that resident #002's specified intervention was discontinued and that the intervention would be taken out of the resident's care plan.

This finding of non-compliance is further evidence to support the Director's Referral (DR) and Compliance Order (CO) #001, related to section (s). 6. (10) (b) of the Long-Term Care Homes Act (LTCHA) 2007, that was issued to the licensee on September 25, 2019, during Follow-Up Inspection #2019_752627_0015, which has a compliance due date of November 25, 2019. [s. 6. (10) (b)]

WN #7: 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 that the home's written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A CI report was submitted by the home to the Director which described allegations of neglect of a number of residents. Please refer to Written Notification (WN) #8 for further details.

A) Inspector #609 reviewed the home's internal investigation and found descriptions of numerous residents in a neglected state.

A review of the home's policy titled "Resident Rights, Care, and Services - Abuse - Zero Tolerance Policy for Resident Abuse and Neglect", last revised April25, 2019, indicated that residents within the facility were to live free of abuse and neglect.

During an interview with PSW #100, they described how they discovered multiple residents in a neglected state on a particular day.

B) The CI report outlined how PSW #101 refused to provide residents with a specific intervention, including support from RN #123.

RN #123 was unavailable for an interview during the inspection.

A review of the plan of care for the residents involved in the incident found that half required the specified intervention.

A further review of the home's internal investigation found that PSW #101 admitted they did not provide the specified intervention the residents required.

PSW #101 received a letter of discipline outlining that the PSW neglected residents.

During an interview with the Administrator, they verified that PSW #101 did not provide the specified intervention to a number of residents, including receiving support from RN #123.

This finding of non-compliance is further evidence to support CO #002 that was issued to the licensee on September 25, 2019, during Complaint Inspection #2019_752627_0016, which has a compliance due date of November 25, 2019. [s. 20. (1)]

WN #8: 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 the person who had reasonable grounds to suspect neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident was immediately reported to the Director.

Neglect is defined in the O. Reg. 79/10 as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A CI report was submitted by the home to the Director which outlined allegations of neglect by PSW #101 towards a number of other residents. Please refer to WN #7 for further information.

A review of the home's policy titled "Resident Rights, Care, and Services - Abuse - Zero Tolerance Policy for Resident Abuse and Neglect", last revised April25, 2019, required that a person who had reasonable grounds to suspect that neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident, immediately reported the suspicion and the information upon which it was based to the Ministry of Long-Term Care.

During an interview with the RCSC, they stated that on a particular day, while conducting the internal investigation into a CI, they found a letter that contained further allegations of neglect of residents by PSW #101. The RCSC acknowledged that they should have immediately reported the information in the letter to the Director.

This finding of non-compliance is further evidence to support CO #003 that was issued to the licensee on September 25, 2019, during Complaint Inspection #2019_752627_0016, which has a compliance due date of December 20, 2019. [s. 24. (1)]

Issued on this 12th day of November, 2019

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

Original report signed by the inspector.