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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 2, 2013	2013_198117_0005	000076-13	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

LONGFIELDS MANOR
330 BEATRICE DRIVE, NEPEAN, ON, K2J-5A5

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

LYNE DUCHESNE (117)

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): March 26 and 27, 2013 on site at the long-term care home.

It is noted that a complaint inspection (Log # O-000251-13) was also conducted at the same time as this Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the home's Executive Director, Director of Care, Resident Care Coordinator, a Royal Ottawa Hospital Psychogeriatric Outreach Registered Nurse, the home's Behavioural Support Ontario (BSO) Personal Support Worker Champion, several Registered Nurses (RN), several Registered Practical Nurses (RPN),several Personal Support Workers (PSW), a housekeeper, a family member as well as to several residents.

During the course of the inspection, the inspector(s) reviewed several identified residents health care records, observed resident care and services, reviewed the home's 2012 and 2013 Mandatory Training calendar, reviewed the home's policies Resident Non-Abuse #LP-B-20 (national) and Resident Non-Abuse #LP-B-20-ON (Ontario) revised October 2012 as well as two Critical Incident Reports.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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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. 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:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The Licensee failed to comply with LTCHA s. 3 (1) (2) in that two identified residents were not protected from sexual abuse by another resident.

As per O.Reg 79/10, sexual abuse is defined as "any non-consensual touching, behaviour or remark of a sexual nature directed towards a resident by a person other then a licensee or staff member".

On an identified date in January, 2013, Resident #1 was reported to have inappropriately touched Resident #2 while both residents were passing each other in the unit hallway. Resident #2 was distressed by the incident and reported it to their family. The family reported the incident to the home. The home implemented short term interventions to monitor Resident #1's behaviour.

In February and March 2013, Resident #1 was noted to have inappropriately touched several other residents and make inappropriate sexual comments. Staff were noted to have intervened and immediately separated the residents at each incident.

On an identified day in March, 2013, Resident #1 was seen by the home's Resident Care Coordinator and staff member #S102 to inappropriately touch Resident #7 while both residents were passing each other in the unit hallway. The Resident Care Coordinator immediately separated both residents. Resident #7 was distressed by the incident. The incident was reported to the resident's legally authorized substitute decision maker. [s. 3. (1) 2.]

WN #2: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The Licensee failed to comply with LTCHA s. 6 (4) (a) in that staff and others involved in the different aspects of care did not collaborate with each other in the assessment of the resident #1 so that their assessments are integrated, and LTCHA s. 6 (4) (b) in the development and implementation of the plan of care, so that the different aspects of care are integrated and are consistent with and compliment each other.

On an identified day in January, 2013, Resident #1 was reported to have inappropriately touched Resident #2 while both residents were passing each other in the unit hallway. Resident #2 was distressed by the incident and reported it to their family. The family reported the incident to the home. The home implemented short term interventions to monitor Resident#1's behaviour.

On an identified day in March, 2013, Resident #1 was seen by the home's Resident Care Coordinator and staff member #S102 to inappropriately touch Resident #7 while both residents were passing each other in the unit hallway. The Resident Care Coordinator immediately separated both residents. Resident #7 was distressed by the incident. The incident was reported to the resident's legally authorized substitute decision maker.

Resident #1's health care record documents that Resident #1 was noted to have inappropriately touched other residents and make inappropriate sexual comments. Notes document that staff intervened and immediately separated the residents at each incident.

- On an identified day in March, 2013 Resident #1 inappropriately touched Resident #3.
- On an identified day in March, 2013 Resident #1 inappropriately touched Resident #4.
- On an identified day in March, 2013 Resident #1 inappropriately touched Resident #5 during the lunch time meal service.
- On an identified day in February, 2013 Resident #1 inappropriately touched Resident #6 prior to the lunch time meal service.
- On an identified day in February, 2013 Resident #1 was heard to make inappropriate sexual comments to a tablemate during the lunch time meal service.

MOH inspector interviewed staff members on March 26 and 27, 2013. Staff members #S102, #S103 and #S104 stated that Resident #1 had been making increasingly

inappropriate sexual comments during the provision of personal care and toileting. Staff members stated that Resident #1's inappropriate sexual comments and behaviours were new. That they started in January 2013, were sporadic at first but were occurring more frequently in the past few weeks. They stated that they did not report to the unit's registered staff changes in Resident #1's behaviours. [s. 6. (4) (a)]

2. Interviewed staff members #S100, #S101, #S107 and #S108 stated that Resident #1 was referred to the home's Behavioural Support Ontario Program (BSO) after the January, 2013 incident with Resident #2. They stated that the BSO team did see Resident #1 but were not aware of the team's recommendations. On March 27, 2013, the interviewed BSO team stated that some written behavioural recommendations had been given to the unit staff in February 2013. The BSO team recommendations were not found in the resident's health care record.

Interviewed BSO team and the DOC stated that they were not aware of the changes in the Resident #1's behaviours during the provision of personal care and toileting. Interviewed staff members #S100, #S101, #S107 and #S108 stated that they also were not aware of Resident #1's inappropriate sexual behaviours during provision of care. The resident's inappropriate sexual behaviours were not identified in the resident's plan of care and no interventions related to these behaviours were noted to be in the resident's plan of care.

As such, the various members of the home's staff did not communicate to each other changes and the increasing frequency of Resident #1's behaviours. This information was not integrated in their assessments and no interventions were developed or implemented between January 2013 to March 2013 in the resident's plan of care related to these inappropriate sexual behaviours. [s. 6. (4) (b)]

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Issued on this 2nd day of April, 2013

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

Lynn Duchesne #117