**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 soins de longue durée**

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| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Nov 15, 2017 | 2017_621547_0014 | 004828-17, 005567-17 | Critical Incident System |

**Licensee/Titulaire de permis**

CVH (No.4) GP Inc. as general partner of CVH (No.4) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Inc. CAMBRIDGE ON  N3H 5L8

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

MANOIR MAROCHEL
949 MONTREAL ROAD OTTAWA ON  K1K 0S6

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

LISA KLUKE (547)

## 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): September 19, 20, 21, 22, 25, 26, 29, October 3, 2017**

**This inspection was related to two critical incidents the home submitted related to:**
**1. an incident of alleged resident to resident abuse**
**2. an incident of alleged staff to resident neglect**

**During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the home's Resident Assessment Instrument (RAI) Coordinator, the Office Manager, a staffing clerk, Physiotherapy Assistant (PTA), the Nutritional Manager, the Dietitian, the Geriatric Psychiatry Outreach Nurse, the Extendicare Assist LTC nursing consultant and the Administrator.**

**In addition, over the course of the inspection, the inspector reviewed residents’ health care records, staff work routines, observed resident rooms, resident common areas, reviewed policies related to abuse and neglect, complaints, continence and specified education reports. The inspector observed the delivery of resident care and services and staff to resident and resident to resident interactions.**

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

**During the course of this inspection, Non-Compliances were issued.**
**3 WN(s)**
**3 VPC(s)**
**0 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 23. Licensee must investigate, respond and act**

**Specifically failed to comply with the following:**

**s. 23. (1) Every licensee of a long-term care home shall ensure that,**
**(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:**
**(i) abuse of a resident by anyone,**
**(ii) neglect of a resident by the licensee or staff, or**
**(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).**
**(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).**
**(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that appropriate action was taken in response to every incident of alleged staff to resident abuse or neglect.

On a specified date, resident #012 and the resident's Substitute Decision Maker (SDM) reported an incident of alleged staff to resident neglect that occurred in the home. Resident #012 reported to the Director of Care (DOC) about the previous shift issue that the PSW staff did not attend to the resident's continence needs as requested by the resident.

Resident #012's health care records identified the resident to be alert and oriented and was able to direct his/her own care. The critical incident report was sent to the Director on a specified date, which indicated the investigation began immediately. This critical incident was amended by the home 11 days later to indicate that PSW #122 did not return any calls to the home and that the allegation of abuse could not be substantiated. The home identified that education would be provided to staff regarding residents rights with specifics related to neglect, and to speak about abuse and how to report abuse.

Resident #012 reported to Inspector #547 on a specified date seven months later, to have recalled this incident clearly and that he/she felt neglected by a PSW during that specified shift. Resident #012 further indicated that he/she was not aware of what PSW staff was working with resident that specified shift, and that this PSW staff member no longer worked in the home after this incident and could assume that the investigation was completed.

On October 3, 2017 the Extendicare Assist Nursing Consultant (EANC) indicated to Inspector #547 that she could not locate any documentation of the investigation records related to this incident. The EANC indicated the Critical Incident Report documented that their investigation was inconclusive for neglect. The EANC indicated that she observed PSW #122's education records that identified this employee received education regarding prevention of abuse and power imbalance on a specified date, a month after this incident, as well as standards of employee conduct two months after this incident. [s. 23. (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 appropriate actions are response to every incident of alleged staff to resident abuse or neglect, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

**Specifically failed to comply with the following:**

**s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,**
**(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).**
**(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).**
**(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the behavioural triggers identified for resident #010 demonstrating responsive behaviours towards resident #011, had strategies developed and implemented to respond to these behaviours, where possible.

This inspection was conducted as a result of a review of a critical incident reported by the home on a specified date regarding an incident of alleged resident to resident physical abuse that occurred this specified date. Resident #010 was observed by PSW # 114 to hit resident #011 on a specified body part, with a specified item causing impaired skin integrity to resident #011.

Inspector #547 reviewed resident #010's health care records and noted resident #010 was admitted to the home with several medical diagnoses including cognitive

impairment.

Resident #010 had a Minimum Data Set (MDS) assessment completed on a specified date, two months prior to this incident, that indicated the resident has persistent anger with self or others and repetitive anxious complaints/concerns having occurred up to five times in the last week prior to this assessment. Resident's mood status, in this assessment was identified as having deteriorated from the previous assessment completed 90 days earlier. The resident's behaviour symptoms were identified as verbally abusive, socially inappropriate/disruptive behaviours and resistance of care, that were not easily altered. The resident assessment protocol summary identified a trigger required for the plan of care, in that resident #010 was very unhappy with the resident across the hall from his/her room. Resident #011 occupied the room across the hall from resident #010.

On a specified date, an interdisciplinary team conference (IDTC) was held which included the RPN/MDS coordinator, and RN #100. The nursing assessment from this meeting documented that resident #010 had resistance to care and had socially inappropriate behaviours. This conference summary documented that resident #010's plan of care was reviewed and was to be updated as required to reflect discussions.

On September 26, 2017 Inspector #547 interviewed the RPN/MDS coordinator in the home regarding the meeting that was held on a specified date eight months earlier and he indicated that all the resident assessment protocol notes are reviewed at the IDTC meeting and the resident's plan of care was supposed to have then been updated. Upon review of resident #010's care plan in place during this incident, updated on a specified date and noted that responsive behaviour triggers that were identified in the IDTC were not identified in the residents plan of care as required. Resident #010's plan of care did not ensure that behaviour triggers that were identified, did not have strategies developed or implemented to respond to these behaviours. [s. 53. (4) (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 resident #010's behavioural triggers that are identified have strategies developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.***

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**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. (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 resident #012 and the resident's Substitute Decision Maker (SDM) were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

On a specified date, resident #012 and the resident's SDM reported an incident of alleged staff to resident neglect that occurred in the home. Resident #012 reported to the Director of Care (DOC) on this specified date about the previous shift issue that the PSW staff did not attend to the resident's continence needs as requested by the resident.

Resident #012's health care records identified the resident to be alert and oriented and was able to direct his/her own care. The Critical Incident Report (CIR) was sent to the Director on this specified date, which indicated that the investigation began immediately. This report identified that resident #012 and the resident's SDM were satisfied that this incident would be investigated. The home amended the CIR to indicate that education would be provided to staff regarding residents rights with specifics related to neglect and reporting of abuse.

Resident #012 reported to Inspector #547 on a specified date that he/she recalled this incident clearly but indicated that he/she was not aware of which PSW staff was working with the resident that night as the resident did not know all the staff names at that time. Resident #012 further indicated that he/she has not seen this PSW staff member and assumed that she no longer worked in the home after this incident.

On October 3, 2017 the Extendicare Assist Nursing Consultant (EANC) indicated to Inspector #547 that she could not locate any documentation of the investigation records related to this incident. The EANC indicated the CIR documented that their investigation was inconclusive for neglect. The EANC was able to confirm that PSW#122 continued to work in the home at this time. The EANC indicated that she could not locate any documentation of any response made to the resident or SDM of the results of the alleged abuse or neglect investigation as required. [s. 97. (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 resident #012 and the resident's SDM are notified of the results related to the identified alleged incident of staff to resident neglect investigation, to be implemented voluntarily.***

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**Issued on this 28th day of November, 2017**

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

**Original report signed by the inspector.**