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 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
Apr 5, 2018	2018_556168_0002	028031-17, 003780-18, 005214-18, 005256-18	Complaint

Licensee/Titulaire de permis

Better Life LTC Inc.
19 Richvalley Crescent RICHMOND HILL ON L4E 4C8

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

Maple Villa Long Term Care Centre
441 Maple Avenue BURLINGTON ON L7S 1L8

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

LISA VINK (168)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 21 and 22, 2018.

The following intakes were inspected during this inspection:
005214-18 - prevention of abuse and neglect;
005256-18 - prevention of abuse and neglect and reporting certain matters to the Director;
028031-17 - prevention of abuse and neglect; and
003780-18 - prevention of abuse and neglect, responsive behaviours and reports regarding critical incidents.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Social Service Worker (SSW), registered nurses (RN), personal support workers (PSW), housekeeping staff, the Life Enrichment Supervisor and residents.

During the course of the inspection, the inspector observed the provision of care, reviewed relevant training records, investigative notes and policy and procedures, and reviewed clinical health records.

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.
- **5 WN(s)**
- **3 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A. For the purpose of LTCHA, 2007, s. 19(1) duty to protect, O Reg. 79/10 s.2(1) defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, action, behaviours or remarks including imposed social isolation, shunning, ignoring, lack of acknowledgement, or infantilization that are performed by anyone other than a resident.

According to Mandatory Report 2408-000003-18 and an interview with resident #001, they witnessed what they believed to be abuse towards resident #002, by PSW #106. After a period of time the resident reported the allegation of abuse to staff at the home, in March 2018.
During the home's internal investigation PSW #106 became aware of the allegation and approached resident #001 regarding the allegation.
The amended report identified that the PSW confronted the resident regarding the alleged incident and the resident was visibly upset with the encounter.
Interview with the resident identified that they were initially "shook up" by the interaction with the PSW, although previously had no concerns with the individual.
According to the Administrator, when interviewed, the PSW verified that they approached the resident regarding the allegation.
Resident #001 was not protected from emotional abuse by PSW #106.

B. For the purpose of LTCHA, 2007, s. 19(1) duty to protect, O Reg. 79/10 s.2(1) defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

According to Mandatory Report 2408-000002-18, resident #003 reported that on an identified date in February 2018, they sustained an injury during attempted care by a PSW.
When the injury was initially identified, the day following the incident, the resident denied pain, according to the progress notes.
Further discussions with the resident identified the staff member to be PSW #106.
In an interview with the resident on March 22, 2018, they indicated their belief that the identified incident caused an injury to an identified area.
PSW #106 was not available for interview regarding the incident.
Resident #003 was not protected from abuse from PSW staff #106. [s. 19. (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 residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #2: 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 the written procedure that promoted zero tolerance of abuse and neglect of residents was complied with.

A. The home's procedure Prevention and Elimination of Abuse and Neglect of Residents, last reviewed January 2017, and currently under revision detailed, on page 9, that "Any person at Maple Villa who witness or suspect the abuse and neglect of a resident, or who receive complaints of abuse or neglect, shall demand the action cease and remove the resident to safety. Call for assistance if needed. And then report the matter immediately to the Administrator (or delegate). Any person must report witnessed or suspected abuse and neglect immediately to the following: the Administrator (or delegate) of Maple Villa and the Ministry of Health and Long-Term Care at the toll free Long-Term Care Action Line".

According to Mandatory Report 2408-000003-18, resident #001 witnessed what they felt was abuse towards resident #002.
Upon investigation it was identified that resident #001 did not initially report their suspicion of abuse to staff; however, after a period of time confided in staff #102.

Interview with staff #102 identified they were informed of the allegation of abuse by resident #001 on an identified date; however, no action was taken to report the abuse at that time, at the request of the resident. The following evening the staff spoke with the resident, regarding the concern and shared the need to report the concern, at which time the resident agreed to speak with a member of the management team regarding the allegation. The resident then spoke with the Life Enrichment Supervisor; however, no action was taken at that time to report the allegation to the Administrator (delegate) or the Director, as requested by the resident and confirmed during an interview with the Supervisor.
The following morning the Life Enrichment Supervisor spoke with the SSW and requested a visit for the resident. The SSW spoke with the resident, who verbalized the allegation and the incident was then reported to the DOC.
The incident was reported to the DOC, by the resident with the SSW, on an identified date in March 2018; however a report was not submitted to the Ministry of Health and Long-Term Care until four days later.

The incident of alleged abuse was known to specific staff in the home for two days prior to the DOC becoming aware of the incident and in total six days before it was reported to the Director.

B. The home's procedure Prevention and Elimination of Abuse and Neglect of Residents, last reviewed January 2017, and currently under revision detailed, on page 6, that "Using the Checklist For Incident Investigation Report, the Director of Care/designate must record details of the incident and obtain written statements from all parties involved (residents, staff members, family members, visitors, volunteer). The Director of Care will provide the Administrator with a complete written, factual report upon completion of the above steps outlined under the protocol".

A request was made for the Checklist for Incident Investigation Reports for the allegations of abuse towards resident #001, #002 and #003.
Interview with the Administrator and DOC identified that the home did not have a Checklist for Incident Investigation Report, tool.
The Administrator and DOC indicated that the allegations were investigated and information was recorded; however, a checklist, as indicated in the procedure, was not completed.
Employees and relevant individuals were spoken to or assessed as part of the investigation process; however, written statements were not consistently received.
The Administrator identified that the identified procedure was currently under review and

a revised procedure was forwarded to the Inspector on March 29, 2018.

Staff did not follow the procedure, Prevention and Elimination of Abuse and Neglect of Residents, as required. [s. 20. (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 the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: 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 failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or might occur, immediately reported the suspicion and the information upon which it was based to the Director, specifically abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm

or risk of harm.

A. During an investigation into Mandatory Report 2408-000003-18 it was identified that resident #001, witnessed what they believed to be abuse towards resident #002, by PSW #106.
During the internal investigation into the allegation, on an identified date in March 2018, resident #001 reported that PSW #106 approached them regarding the allegation.
Interview with the Administrator identified that in their opinion the interaction between resident #001 and PSW #106 resulted in undo stress to the resident and was considered emotional abuse according to the home's procedure Prevention and Elimination of Abuse and Neglect of Residents, last reviewed January 2017 and currently under revision.
The incident of abuse towards resident #001 was not reported to the Director, until the omission was identified by the Inspector, approximately two weeks later as verified during an interview with the Administrator and identified on the report.
The grounds to suspect that abuse had occurred were not immediately reported to the Director.

B. The Life Enrichment Supervisor verified during an interview with the Inspector that they became aware of an allegation of abuse, reported by resident #001, towards resident #002, by PSW #106 on an identified date in March 2018. The Life Enrichment Supervisor did not report the suspicion of abuse and the information upon which it was based to the Director immediately.
The following day, the allegation was reported to the SSW and subsequently to the DOC that same day, as communicated by the SSW.
The DOC notified the Director of the allegation, via the completion of a Mandatory Report, four days later, as confirmed by the DOC.
The allegation of abuse was not reported to the Director immediately as required.

C. According to the progress notes on an identified date in February 2018, at approximately 2125 hours, resident #003 reported to RN #110 that PSW #106 grabbed them in an identified area and attempted the provision of care. Initial assessment did not include any evidence of injury or trauma. The RN provided reassurance to the resident, redirected the PSW and provided shift report to the oncoming day RN; however, did not report the incident to the Director.
The day after the incident, the resident was assessed, an injury was identified and the Director was notified via the after hours Ministry reporting system, by RN #109.
Interview with the DOC identified that following the incident they spoke with RN #110 and provided direction that they should have notified management immediately of the

incident, regardless of the time of day.
When interviewed on March 22, 2018, RN #110 identified that they did not feel that the incident was abuse until the injury was noted. In their opinion at the time of the incident, it was more a case of not following the plan of care for known identified care needs of the resident.
RN #110 verified that they had received abuse training in the home in the past year and was able to verbalize different types of abuse.
Training records, provided by the home, identified that RN #110 and RN #109 each reviewed and understood the home's Prevention of Abuse and Neglect and Whistle Blowing Protections policy/procedures in March 2017.
The abuse was not reported to the Director immediately, as required. [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 person who has reasonable grounds to suspect that any of the following has occurred or might occur, immediately report the suspicion and the information upon which it is based to the Director, specifically abuse of a resident by anyone or neglect of a resident by the licensee or staff that results in harm or risk of harm, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #001 witnessed what they believed was abuse and verbalized this information to the Life Enrichment Supervisor, in March 2018, an unknown period of time after the alleged incident.
When interviewed, on March 21, 2018, the Life Enrichment Supervisor identified that when they spoke with the resident, regarding the alleged incident they were able to tell that the resident was upset and took their hands in theirs for support.
Then on an identified date, resident #001 was confronted about the allegation of abuse by PSW #106.
A review of Mandatory Report 2408-000003-18, which was amended noted that the resident was "visibly upset by the encounter", that information was provided by the Administrator and actions were taken to help the resident calm down.

There was no documentation in the clinical record of the interventions taken to respond to the needs of the resident nor the resident's response as verified by the DOC following a review of the progress notes. [s. 30. (2)]

WN #5: 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 failed to ensure that the report to the Director included the following description of the individuals involved in the incident, the names of any staff members or other persons who were present at or discovered the incident.

A review of Mandatory Report 2408-000002-18, submitted in February 2018, for 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 did not include the names of the staff person present at the time of the incident.
The report did not include the name of the PSW who the resident identified to be involved in the incident until it was identified by the Inspector on March 22, 2018, as confirmed by the DOC.
Discussion with the DOC identified that they may have included this information in the report; however, forgotten to push the "add" button to have it recorded in the electronic form submission, a technical error.

The report to the Director did not include all of the required information. [s. 104. (1) 2.]

Issued on this 19th day of April, 2018

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

Original report signed by the inspector.