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
Oct 15, 2019	2019_785732_0029	008491-19, 008553-19, 015429-19, 015673-19, 015674-19, 015748-19, 015885-19, 015908-19, 015981-19, 016451-19, 018150-19, 018158-19	Critical Incident System

Licensee/Titulaire de permis

Marianhill Inc.
600 Cecelia Street PEMBROKE ON K8A 7Z3

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

Marianhill Nursing Home
600 Cecelia Street PEMBROKE ON K8A 7Z3

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

EMILY BROOKS (732), MEGAN MACPHAIL (551)

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 23 to 27, 2019

The following intakes were completed during this Critical Incident System inspection:

Log #015429-19 (CIR #2702-000022-19) and log #018150-19 (CIR #2702-000033-19) related to controlled substance missing/unaccounted for.

Log #015673-19 (CIR# 2702-000014-19), log #008491-19 (CIR #2702-000012-19), and log #015674-19 (CIR #2702-000015-19) related to alleged staff to resident abuse.

Log #016451-19 (CIR #2702-000030-19), log #015885-19 (CIR #2702-000024-19), log #015908-19 (CIR #2702-000025-19), log #015748-19 (CIR #C536-000001-19), log #015981-19 (CIR #2702-000026-19), and log #018158-19 (CIR #2702-000034-19) related to alleged resident to resident sexual abuse.

Log #008553-19 (CIR #2702-000013-19) related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), the Director of Care (DOC), unit managers, a Registered Nurse (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), a Physiotherapist (PT) and residents.

The inspector(s) reviewed resident health care records, relevant investigation records, and relevant policies and procedures; as well as observed the provision of care and services to residents, staff to resident interactions, and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

4 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 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 written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

According to the licensee's policy tilted 'Abuse, Neglect and Retaliation' (last revised 03-2019), the suspected/actual abuse of a resident is to be reported to the MOHLTC (Ministry of Health and Long-Term Care) according to this policy. Number one of the Reporting Procedure stated that any employee who witnesses or suspects abuse/neglect of a resident must immediately report the incident or suspicion to the RN in charge/Unit Manager/Director of Care or the CEO/designate.

On the evening shift of a specified date, there was a witnessed incident of staff to resident abuse involving resident #005 and PSW #117. According to PSW #109, they saw PSW #117 grab the resident forcefully, and the resident sustained a skin tear.

Furthermore, on that same shift, there was a witnessed incident of staff to resident abuse involving resident #003 and PSW #117. According to PSW #109, they saw PSW #117 using force while providing peri-care to resident #003, causing the resident to cry out in pain and try to squirm away.

PSW #109 did not report the allegation until the following day when they contacted RPN #102. RPN #102 reported the information to unit manager #101, and an investigation was initiated. As a result of the licensee's investigation, PSW #117's employment was terminated. [s. 20. (1)]

2. The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Five Critical Incident Reports (CIR's) were submitted to the Director, all describing alleged sexual abuse from resident #001 to resident #002.The CIR's described resident #001 grabbing the chest of resident #002.

Sexual abuse is defined in Ontario Regulation 79/10 as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Upon review of resident #001's progress notes for the above-mentioned incident, Inspector #732 noted alleged sexual abuse from resident #001 towards resident #002 on a specified date. The progress note documented by RPN #115 described that RPN #115 was assisting staff in another resident room when yelling was heard from hallway. Resident #001 was grabbing resident #002's chest, and resident #002 was yelling. Residents were separated and resident #001 was noted to be smiling. No further occurrences after this. RN supervisor was informed.

Inspector #732 reviewed the licensee's policy and procedure entitled 'Abuse, Neglect and Retaliation', effective 07-2006, revised 03-2019. The policy indicated under 'Reporting Procedure', that any employee who witnesses or suspects abuse/neglect of a resident must immediately report the incident or suspicion to the RN in charge/Unit Manager/Director of Care or the CEO/designate. It then instructed that the RN in charge/Unit Manager/Director of Care or the CEO/designate initiate the Decision Tree of Abuse to determine next step. Then it described that the RN in charge notify the unit manager/Director of Care/CEO immediately and the CEO/designate will immediately notify the MOHLTC, and that the Director of Care/designate will conduct an immediate investigation. Furthermore, under 'Policy Statement' it specifies that all staff are held accountable under the legislation to this requirement to report, and that staff who suspect or witness abuse have a responsibility to ensure that the reporting under the legislation to the MOHLTC occurs.

Unit manager #119 and unit manager #118 were the unit managers scheduled at the time of the alleged sexual abuse incident on a specified date. Unit manager #118 told Inspector #732 that they did not recall hearing about that incident. Unit manager #119 reviewed the progress note from RPN #115 on a specified date, noting that nothing was brought to their attention about that incident, and until the first CIR was submitted on a specified date, alleging sexual abuse from resident #001, they were unaware of the extent of resident #001's behaviours of a sexual nature.

In an interview, DOC #100 informed Inspector #732 that resident #002 is not capable of consent. DOC #100 explained that RPN's are to report incidents of suspected abuse to the RN in charge or unit manager and then the unit manager or themselves will submit the CIR. Unit manager #101 explained that RN's in charge should report to any unit manager or the DOC so that a CIR can be submitted. DOC #100 and unit manager #101 informed Inspector #732 that they were unaware of any other incident of sexual abuse by resident #001 besides the five CIR's submitted.

As per the licensee's policy entitled 'Abuse, Neglect and Retaliation', the reporting procedures as outlined in the policy, including conducting an investigation, were not complied with, and staff failed to ensure that the reporting under the legislation to the Director occurred. [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 there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy is complied with, to be implemented voluntarily.

WN #2: 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 that abuse of a resident by anyone occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A Critical Incident Report (CIR) was sent to the Director on a specified date, at a specified time, under LTCHA s. 24 (1), to report an allegation of staff to resident abuse.

According to the CIR, the incident occurred on a specified date, during the provision of care, and involved resident #005 and PSW #117. The incident was witnessed by PSW #109.

In an interview with PSW #109, they reported that they were called to resident #005's bathroom to assist PSW #117 in taking the resident off the toilet. PSW #109 stated that PSW #117 grabbed the resident forcefully, and the resident sustained a skin tear.

The following morning, PSW #109 reported to RPN #102 that PSW #117 had been rough during the provision of care the evening prior.

The Director was not immediately informed of the allegation of staff to resident abuse; the Director was not informed until the following day. [s. 24. (1)]

2. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A CIR was sent to the Director on on a specified date, at a specified time, under LTCHA s. 24 (1), to report an allegation of staff to resident abuse.

According to the CIR, the incident occurred on a specified date during the provision of peri-care and involved resident #003 and PSW #117. The incident was witnessed by PSW #109.

In an interview with PSW #109, they reported that PSW #117 used force while doing peri-care, and that the resident was crying out in pain and tried to squirm to the top of the bed.

The following morning, PSW #109 reported to RPN #102 that PSW #117 had been rough during the provision of care the evening prior.

The Director was not immediately informed of the allegation of staff to resident abuse; the Director was not informed until the following day. [s. 24. (1)]

3. The licensee has failed to ensure that a person who had reasonable grounds to suspect that sexual abuse of a resident by anyone had occurred or may occur, shall immediately report the suspicion and the information upon which it is based to the Director.

As mentioned in WN #1, an incident of alleged sexual abuse by resident #001 to resident #002 was documented in resident #001's progress notes on a specified date.

In an interview, DOC #100 informed Inspector #732 that resident #002 is not capable of consent. DOC #100 explained that RPN's are to report incidents of abuse to the RN in charge or unit manager and then the unit manager or themselves will submit the CIR. DOC #100 and unit manager #101 informed Inspector #732 that they were unaware of any other incidents of alleged sexual abuse by resident #001 besides the five CIR's submitted.

Unit manager #119 told Inspector #732 that until the first CIR was submitted on a specified date, alleging sexual abuse from resident #001, they were unaware of the

extent of resident #001's behaviours of a sexual nature.

Therefore, the licensee has failed to ensure that an incident of alleged sexual abuse by resident #001 was immediately reported to the Director. [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 abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #3: 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 #006 fell, the resident was assessed, and if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

According to the Interdisciplinary Falls Prevention and Management Program (reviewed July 2019), when a resident has fallen, the resident will be assessed regarding the nature of the fall and associated consequences using the post falls assessment tool on Point Click Care (PCC). In an interview with unit manager #101, they stated that after each fall, a post fall assessment was to be conducted.

A review of resident #006's health care record indicated that since their admission, the resident had fallen sixty (60) times.

A post-assessment using the post falls assessment tool on PCC was not conducted following 24 falls on specified dates.
[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 #4: 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 the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence.

On a specified date, there were two witnessed incidents of staff to resident abuse involving resident #005 and PSW #117 and resident #003 and PSW #117. The incidents were reported to the licensee the next day.

In an interview with unit manager #101, they indicated that they phoned the police the day after becoming aware of the witnessed incidents of staff to resident abuse, and that they should have phoned the day prior, upon becoming aware of the allegation.

According to unit manager #101, a police officer responded to the home, and PSW #117 has been charged with assault under criminal code 266. [s. 98.]

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 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., to be implemented voluntarily.

Issued on this 15th day of October, 2019

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

Original report signed by the inspector.