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 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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
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347 rue Preston bureau 420
OTTAWA ON K1S 3J4
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 27, 2018	2018_505103_0031	015100-18, 021620-18, 024581-18, 026112-18, 026183-18, 027777-18, 028556-18	Critical Incident System

Licensee/Titulaire de permis

County of Prince Edward
603 Highway 49 R.R. #2, Hallowell Township PICTON ON K0K 2T0

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

H.J. McFarland Memorial Home
603 Highway 49, R.R. #2, Hallowell Township PICTON ON K0K 2T0

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

DARLENE MURPHY (103)

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 31, November 1, 2, 5-8, 13, 2018.

The following intakes were included in this inspection:
Log #015100-18 (CIS#M556-000027-18) and Log #026112-18 (CIS#M556-000044-18)- resident falls that resulted in injury,
Log #028556-18 (CIS#M556-000047-18, CIS#M556-000049-18, CIS#M556-000050-18, CIS#M556-000051-18, CIS#M556-000052-18)- alleged incidents of staff to resident abuse,
Log #021620-18 (CIS#M556-000038-18), Log #024581-18 (CIS#M556-000041-18), Log #026183-18 (CIS#M556-000045-18) and Log #027777-18 (CIS#M556-000046-18)- alleged incidents of resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), the office manager, the Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector reviewed resident health care records, critical incidents (CIS) submitted by the home and relevant to this inspection, the home's abuse policy, observed residents and resident care.

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

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
0 VPC(s)
1 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. 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. A person who had reasonable grounds to suspect an incident of resident sexual abuse had occurred, failed to report the suspicions immediately to the Director, Ministry of Health and Long Term Care (MOHLTC).

O. Reg 79/10, s. 2 (1) (a) defines sexual abuse as any consensual or non-consensual touching, behavior or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member.

On a specified date, PSW #102 reported to the DOC that they had been made aware of an alleged incident of sexual abuse involving resident #010 and PSW #111. The DOC initiated an immediate investigation into the allegations and took measures to safe guard the residents including reporting the incident as required by the legislation to the MOHLTC, the police and the substitute decision makers (SDM).

PSW #102 was interviewed by this inspector and stated while providing care to resident #010, the resident disclosed an incident involving PSW #111. The PSW indicated they provided reassurance to resident #010 and then discussed the incident with two PSW’s also working the same shift. PSW #102 stated after their discussion with the co-workers, they believed several additional staff were aware of similar incidents and had never reported them. PSW #102 stated they did not immediately report the incident to the registered nurse in charge or a manager upon being made aware of the incident. The

PSW indicated they knew they should have immediately reported it, but chose to disclose the incident directly to the DOC, six days later.

During the home's investigation into this alleged incident of sexual abuse, subsequent incidents involving residents #006, #007, #008 and #009 were disclosed by PSW's #103, #104 and #105.

PSW's #103, #104 and #105 were interviewed about the incidents. PSW #103 stated they had witnessed incidents involving PSW #111 and residents #009 and #007. PSW #103 indicated they had spoken with PSW #111 directly about the incidents. PSW #103 indicated the incidents were not reported to the charge nurse or a manager, but stated they felt the incidents crossed the line and they should have reported them.

PSW #104 was interviewed and stated they were aware of an unwitnessed incident reported to them by resident #008. PSW #104 indicated they intended on discussing the incident directly with PSW #111, but got busy with work and never did. PSW #104 stated the incident was not reported to a charge nurse or manager.

PSW #105 indicated they had never witnessed any incidents, but overheard comments from residents #006 and #009 in regards to PSW #111's actions and stated the comments made them feel uncomfortable. PSW #105 indicated they did not report these incidents to a charge nurse or a manager, but did disclose the information at a subsequent time to PSW #109 who indicated they should report the incidents.

PSW #111 was interviewed and indicated at the time of the incidents they had not considered their actions to be inappropriate. PSW #111 confirmed they had received annual abuse training and stated they did recall this type of behavior being outlined during their PSW education as inappropriate.

The Administrator was interviewed in regards to these incidents and stated the actions were inappropriate and viewed them as taking advantage of vulnerable residents. [s. 24. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 has failed to ensure the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

As outlined in WN #1, alleged, suspected and witnessed incidents of staff to resident sexual abuse involving residents #006, #007, #008, #009 and #010 and PSW #111 were not immediately reported.

The home's abuse policy was reviewed, "Prevention of Abuse and Neglect of a resident", #VII-G-10.00 (last updated in January 2018) and indicated all employees are required to immediately report any suspected or known incident of abuse and neglect to the Director of MOHLTC and the Executive Director/Administrator or designate in charge of the home. The abuse policy also defined sexual abuse as any consensual or non-consensual touching, behaviour, or remarks of a sexual nature that is directed to a resident by a licensee or staff member.

PSW’s #102, #103, #104, #105 and #109 failed to comply with the home’s abuse policy in regards to the reporting of these alleged, suspected and witnessed incidents. [s. 20. (1)]

Issued on this 28th day of November, 2018

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DARLENE MURPHY (103)
Inspection No. / No de l'inspection :	2018_505103_0031
Log No. / No de registre :	015100-18, 021620-18, 024581-18, 026112-18, 026183-18, 027777-18, 028556-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 27, 2018
Licensee / Titulaire de permis :	County of Prince Edward 603 Highway 49, R.R. #2, Hallowell Township, PICTON, ON, K0K-2T0
LTC Home / Foyer de SLD :	H.J. McFarland Memorial Home 603 Highway 49, R.R. #2, Hallowell Township, PICTON, ON, K0K-2T0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kim Mauro

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To County of Prince Edward, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

The licensee must be compliant with s. 24 (1) of the LTCHA.

Specifically the licensee shall:

a) ensure all alleged, suspected or witnessed incidents of sexual abuse involving residents #006, #007, #008, #009, #010 and any other residents are immediately reported to the Director (MOHLTC),
b) provide education session(s) on resident sexual abuse to PSW's #102, #103, #104, #105, #109 and #111 which includes:
- the definition of resident sexual abuse by staff members and a variety of relevant examples and scenarios,
-the obligation to immediately report all alleged, suspected or witnessed incidents of resident sexual abuse to the Director (MOHLTC),
c) provide additional education to PSW #111 related to power imbalance as it relates to the provision of resident care,
d) complete post education testing to ensure understanding of the information provided,
e) maintain a written record of all education and post testing provided,
f) develop a written plan that outlines the actions that will be taken by the management team when staff members fail to comply with the immediate reporting of all alleged, suspected or witnessed incidents of resident abuse and communicate this plan to all staff.

Grounds / Motifs :

1. A person who had reasonable grounds to suspect an incident of resident sexual abuse had occurred, failed to report the suspicions immediately to the Director, Ministry of Health and Long Term Care (MOHLTC).

O. Reg 79/10, s. 2 (1) (a) defines sexual abuse as any consensual or non-consensual touching, behavior or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member.

On a specified date, PSW #102 reported to the DOC that they had been made aware of an alleged incident of sexual abuse involving resident #010 and PSW #111. The DOC initiated an immediate investigation into the allegations and took measures to safe guard the residents including reporting the incident as required by the legislation to the MOHLTC, the police and the substitute decision makers

(SDM).

PSW #102 was interviewed by this inspector and stated while providing care to resident #010, the resident disclosed an incident involving PSW #111. The PSW indicated they provided reassurance to resident #010 and then discussed the incident with two PSW's also working the same shift. PSW #102 stated after their discussion with the co-workers, they believed several additional staff were aware of similar incidents and had never reported them. PSW #102 stated they did not immediately report the incident to the registered nurse in charge or a manager upon being made aware of the incident. The PSW indicated they knew they should have immediately reported it, but chose to disclose the incident directly to the DOC, six days later.

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The Administrator was interviewed in regards to these incidents and stated the actions were inappropriate and viewed them as taking advantage of vulnerable residents.

The severity of these incidents was determined to be a level 2 as there was potential for actual harm to the residents. The scope of the incidents was a level 3 as it related to all of the residents reviewed. The home had a level 4 history of ongoing non-compliance with this section of the Act that included:
LTCHA, s. 24- Voluntary Plan of Correction (VPC) issued April 18, 2016 (2016_236622_0010),
LTCHA, s. 24- VPC issued July 7, 2016 (2016_280541_0016),
LTCHA, s. 24- VPC issued March 6, 2017 (2016_505103_0007),
LTCHA, s. 24- Compliance order (CO) issued April 16, 2018 (2018_505103_0007), and
one related non-compliance, LTCHA, s. 20- VPC issued April 16, 2018 (2018_505103_0007).

(103)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 18, 2018

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 27th day of November, 2018

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : DARLENE MURPHY

Service Area Office / Bureau régional de services : Ottawa Service Area Office