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
Feb 5, 2018	2017_617148_0036	021520-17, 022662-17, 023757-17, 023762-17, 023805-17, 024997-17, 027976-17	Critical Incident System

Licensee/Titulaire de permis

City of Ottawa
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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

Peter D. Clark Centre
9 Meridian Place OTTAWA ON K2G 6P8

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

AMANDA NIXON (148)

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): December 6, 7, 8, 13, 18, 19, 20 and 21, 2017

This inspection included seven reported critical incidents: four related to alleged staff to resident abuse, two related to resident to resident alleged sexual abuse and one related to the force feeding of an identified resident.

A complaint log (Inspection Report #2017_708548_0027 by Inspector #548) related to alleged neglect of a resident was conducted concurrently during this inspection and information was added to this report

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Program Manager of Resident Care (PMORC), Program Manager of Personal Care (PMOPC), Administrative Assistant, Scheduler, Registered Dietitian, Food Service Worker, Long Term Care Trainer, Manager of Hospitality Services, Registered Nurses, Registered Practical Nurses, Personal Support Workers, family members and residents.

The Inspector reviewed documents contained within the identified resident health care records, observed resident care and services along with the resident's environment. In addition, the Inspector reviewed documents related to the licensee investigations into the alleged incidents of resident abuse and the licensee's policy to promote zero tolerance of abuse and neglect.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Training and Orientation

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

3 WN(s)
2 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. 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 policy to promote zero tolerance of abuse and neglect of residents, is complied with.

The home’s policy to promote zero tolerance of abuse and neglect of residents revised June 2017 and November 2017, #750.65. Both revisions of this policy includes a statement under the definition of sexual abuse: Any resident behaviour of a sexual nature must be assessed using the Assessing Capacity to have an Intimate Sexual Relationship algorithm (Appendix B) to determine if the residents involved have the capacity to consent to the relationship.
Appendix B includes the following:
Assessing Capacity to have an Intimate Sexual Relationship
Mini –Mental
Is the Resident’s Mini-Mental stated score greater than 14
Resident’s Ability to Avoid Exploitation: Is the behaviour consistent with formerly held beliefs/ values? Does the resident have the capacity to say no (verbally or Non-verbally) to any uninvited sexual contact?
Resident’s Awareness of the Relationship: Is the Resident aware of who is initiating the sexual contact?
Does the Resident believe that the other person is a spouse or partner? Are they aware of the other’s identity and intent? Can the resident state what level of sexual intimacy they would be comfortable with?
Resident’s Awareness of Potential Risks: Does the Resident realize that this relationship may be time Limited? Can the Resident describe how they will react when the relationship ends? Is the resident able to respond to questions adequately (Verbally or Non-verbally)?

On a specified date, the home's manager on call submitted an after hours pager report describing an incident of alleged sexual abuse between two residents #001 and #003. A critical incident report was submitted by the home's PMORC, which stated that staff members responding, PSW #112 and RN #104, separated the two residents. Additional actions included to increase monitoring, referral to mental outreach and screening for urinary infection.

On another specified date, the home's PMORC submitted a critical incident report describing an incident of alleged sexual abuse between residents #001 and #003. Actions from the staff members responding, PSW #110, RPN #105 and RN#104, included to separate the two residents and provide monitoring. On the following day, RN #102 spoke with the residents indicating that they could not have interactions of a sexual nature and that one of them would be moved to the other side of the unit.

Inspector #148 spoke with RN #105, who was able to identify that the home's abuse policy included a guide for the assessment of capacity. RN #105, expressed that she did not feel clear on the application of appendix B, describing that she was unsure how the answers to the questions, in conjunction with the mini-mental, would be applied in the decision to determine capacity or where such an assessment would be documented.

The Inspector spoke with RN #102, who was the regular day RN for the identified unit at the time of the incidents and is currently in the Acting PMOPC position. In a discussion related to the capacity of resident #001 and #003, RN #102 identified that resident #003 is capable but that resident #001 is not. RN #102 indicated that a capacity assessment is not conducted by registered staff in the home. In discussion about capacity, RN #102 identified documents and/or actions from the placement coordinator that would support the level of capacity. RN #102 noted that if a capacity assessment was required that the home's social worker would likely be involved in coordinating an external person to conduct the assessment. The Inspector presented the home's policy as described above, RN #102 was not clear if she had seen or was aware of the content related to capacity under sexual abuse. She was not aware if an assessment, as described by Appendix B, had been completed with either resident #001 or #003.

Inspector #148 spoke with the home's Administrator, he described that consideration was made with respect to each of the resident's capacity. He noted that given the remorse of resident #001 and information already on the health care record that resident #001 was not capable.

The home could not demonstrate that an assessment of capacity had been conducted as outlined by the home's policy to promote zero tolerance of abuse and in this way staff did not complied with the licensee's policy to promote zero tolerance of abuse and neglect of residents. (Log 022662-17, 023805-17) [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 ensure that the policy to promote zero tolerance of abuse and neglect of resident, is complied with; specifically as it relates to the assessment of capacity in instances of alleged sexual abuse, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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 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 a risk of harm to the resident, has occurred or may occur shall

immediately report the suspicion and the information upon which it is based to the Director.

On a specified date, the home’s PMORC submitted a critical incident report describing an incident of alleged sexual abuse between residents #001 and #003. This was the second known incident of a similar nature between the two residents. The immediate action from the staff members responding, PSW #110, RPN #105 and RN#104, included to separate the two residents. On the following day, RN #102 spoke with the residents indicating that they could not have interactions of a sexual nature and that one of them would be moved to the other side of the unit.

The Inspector #148 spoke with both resident #001 and resident #003 and reviewed their health care records, as appropriate. Both residents have a diagnosis of dementia but are able to participate in various activities of daily living. A recent assessment of resident #001 by mental outreach noted that resident #001 was aware of his/her actions as it related to the reported alleged sexual abuse and that the actions may be related to disinhibition and a true attraction to the co-resident.

Inspector #148 spoke with PSW #110, who reported that he had reported the discovery of the two residents to RPN #105, as he was unsure of the resident’s capacity. During discussion with PSW #110 he was aware of the home’s internal reporting processes including his responsibility to report to his immediate supervisory staff (RPN and/or RN) of any alleged abuse. RPN #105 indicated to the Inspector that on the evening of the incident, she did not feel that the incident was abuse but felt that due to the wishes expressed by the substitute decision maker for resident #001, that the residents needed to be separated. In an interview with RN #104 it was indicated that the incident was possible abuse, she stated that the competency was not fully known at the time and so the residents were separated.

On a specified date, three staff members including two supervisory staff members were aware of an alleged sexual abuse between resident #001 and #003. A report of the suspected sexual abuse was reported to the Director one day after the incident by the home’s PMORC. (Log 023805-17)

2. On a specified date, the PMOPC submitted a critical incident report describing alleged emotional and physical abuse involving resident #001 and PSW #122. The PMOPC indicated in the critical incident that this information was provided to her by email six days

earlier.

Inspector #148 spoke with RN #102 who confirmed that she had met with the resident, the resident's spouse and family friend about the care and services provided by PSW #122, including comments of alleged emotional and physical abuse. RN #102 described her actions to be an email to her supervisor the PMOPC and to change the care scheduel so as to accommodate resident #001's preferences for staff. When interviewed by the Inspector, RN #102 indicated that the information received she received, may have been emotional abuse but that the resident has been known to confabulate in the past. By way of the home's investigation file, it was determined that action was taken on the resident's report on the same date as the submitted critical incident report, when the family friend approached the PMOPC about concerns related to PSW #122. Information was known by two supervisory staff members on a specified date, related to alleged physical and emotional abuse. A report of this suspected abuse was reported to the Director six days later. (Log 021520-17)

3.On a specified date, in an email correspondence from the resident's Substitute Decision-Maker (SDM) to the PMORC, the SDM described an incident of neglect involving resident #002. The PMOPC, is responsible for personal support workers at the home.

The PMOPC indicated to Inspector #548 that reporting of incidents to the Director is a shared responsibility between the managers and Administrator. She indicated that if there is an issue specifically concerning the care being provided by the personal support workers she would be responsible to report this information to the Director and conduct an investigation of the incident.

The home's investigative notes were reviewed. During an interview with Inspector #548, the PMOPC indicated that she became aware on a specified date, from the forwarded email, of the alleged incident of neglect and began an investigation. She indicated that she corresponded with the resident's SDM.

The PMOPC indicated to Inspector #548 that the incident was cause for concern and she informed the Administrator of the incident on a specified date. She indicated that she was informed by the Administrator that the allegation of abuse/neglect was to be immediately reported to the Director.

The PMORC and PMOPC both failed to immediately report an incident of alleged

abuse/neglect when they received an email from the SDM; the incident was reported three days. (026654-17, Inspector #548) [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 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, has occurred or may occur 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 LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of every investigation undertaken as it relates to abuse of a resident by anyone, is reported to the Director.

On a specified date, the PMOPC submitted a critical incident report describing that a family member of resident #012 observed PSW #133 making remarks and actions toward the resident that may have been threatening; alleged emotional abuse.

It was demonstrated that the PMOPC conducted an investigation into the matter. The investigative file denotes that PSW #133 was provided a letter from the PMOPC, indicating that the PSW was to review the practice and procedure titled Abuse #750.65, the Resident Bill of Rights and LTCHA information about abuse and acknowledgement understanding of prevention of abuse policy. Further to this, the letter stated that PSW #133 would be expected to provide total resident care according to the resident care plan that provide for optional functioning and well-being in a supportive, therapeutic environment with an emphasis on resident safety and engagement.

In discussion with the Manager of Hospitality Services who was involved in the investigative interviews and the home’s Administrator, the outcome of the investigation was unclear. The licensee did not report to the Director the results of the investigation undertaken as it related to a reported alleged emotional abuse. (Log 024997-17) [s. 23. (2)]

Issued on this 6th day of February, 2018

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

Original report signed by the inspector.