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
Sep 6, 2019	2019_746692_0020	001680-19, 006046-19, 007619-19	Critical Incident System

Licensee/Titulaire de permis

The District of the Municipality of Muskoka
98 Pine Street BRACEBRIDGE ON P1L 1N5

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

The Pines
98 Pine Street BRACEBRIDGE ON P1L 1N5

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

SHANNON RUSSELL (692)

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): August 26-29, 2019.

The following intakes were inspected upon during this Critical Incident Inspection:
- One log related to a critical incident that the home submitted to the Director regarding an incident of resident to resident sexual abuse;
- One log related to a critical incident that the home submitted to the Director regarding an injury that resulted in a transfer to hospital; and,
- One log related to a critical incident that the home submitted to the Director in relation to an allegation of staff to resident verbal and emotional abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Activity Aide, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions and resident to resident interactions, reviewed relevant health care records, internal investigation notes, as well as licensee policies, procedures and programs.

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.
- **1 WN(s)**
- **1 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 home's written policy to promote zero tolerance of abuse was complied with.

A Critical Incident System (CIS) report was submitted to the Director on an identified date, which indicated that four days prior, resident #002 was observed to be displaying a responsive behaviour of a sexual nature towards resident #003. Resident #003 stated that they were "scared" at the time of the incident.

Sexual abuse is defined within the Ontario Regulations 79/10 of the Long-Term Care Homes Act (LTCHA) 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."

Inspector #692 reviewed resident #002's health care records, identifying a progress note, dated on an identified date, documented by Registered Practical Nurse (RPN) #102, which indicated that they observed resident #002 exhibiting a responsive behaviour of a sexual nature towards resident #003. A review of resident #002's care plan, in effect at the time of the incident, indicated that resident #002 had a history of responsive behaviours of a sexual nature towards others.

A review of the home's policy titled, "Extendicare Zero Tolerance of Abuse and Neglect: Response and Reporting, #RC-02-01-02", last updated April 2017, indicated that "any employee or person who [became] aware of an alleged, suspected or witnessed resident incident of abuse or neglect [was to] report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at that time".

During separate interviews with Personal Support Worker (PSW) #100 and RPN #102, they both identified that resident #002 had a history of exhibiting responsive behaviours of a sexual nature towards others. Both PSW #100 and RPN #102 indicated that on an identified date, they observed resident #002 exhibiting a responsive behaviour of a sexual nature towards resident #003. They indicated that they intervened, redirected resident #002 from the area, and assessed resident #003, who stated, "[they were] scared". RPN #102 indicated that they had not believed the incident was considered an allegation of sexual abuse, therefore had not reported the incident to management until four days after the incident had occurred.

Inspector #692 interviewed Registered Nurse (RN) #111, who identified that staff were to

report any incidents of suspected or confirmed abuse of a resident to the RN, who in turn would report it to the senior management.

In an interview with the Director of Care (DOC), they identified that staff were to report all witnessed, suspected or confirmed incidents of resident abuse to senior management immediately at the time the incident occurred. The DOC confirmed that the incident involving resident #002 exhibiting a responsive behaviour of a sexual nature towards resident #003 was not reported to management immediately, and it should have been. [s. 20. (1)]

2. A CIS report was submitted to the Director on an identified date, which indicated that six days prior, Activity Aide #105 had observed an incident between RPN #107 and resident #001. The CIS report further indicated that Activity Aide #105 stated that RPN #107 was forceful in their interactions with resident #001. Activity Aide #105 further indicated that the day after the incident resident #001 described the incident to them, and became agitated, when RPN #107 walked by them.

Emotional abuse is defined within the Ontario Regulations 79/10 of the Long-Term Care Homes Act (LTCHA) as "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that [were] performed by anyone other than a resident".

a)Inspector #692 reviewed the home's internal investigation notes, identifying that Activity Aide #105 confirmed to management that they had witnessed the incident between RPN #107 and resident #001, resulting in resident #001 becoming upset and agitated.

A review of the home's policy titled, "Extendicare Zero Tolerance of Abuse and Neglect: Response and Reporting, #RC-02-01-02", last updated April 2017, indicated that any form of abuse by any person interacting with residents, whether through deliberate acts or negligence, will not be tolerated.

b) A further review of the home's interval investigation notes, identified that Activity Aide #105 did not report the incident that they had observed to their supervisor until six days after the incident occurred.

During an interview with Activity Aide #105, they indicated that on an identified date they had witnessed an incident between RPN #107 and resident #001. They indicated that

resident #001 became upset and agitated after this occurred, describing to Activity Aide #105 what occurred. They indicated that they had not reported the incident until six days after the incident had occurred.

Inspector #692 interviewed RPN #107, who described their actions on the specified date towards resident #001. RPN #107 identified their actions could have been misunderstood by whoever witnessed it. RPN #107 identified that they had received disciplinary action at the time of the incident.

In an interview with RN #111, they indicated that if staff were to witness an incident of abuse directed towards a resident, they were required to report it to the RN or senior management immediately. RN #111 stated that the incident involving RPN #107 had not been reported at the time of the incident, and that Activity Aide #105 should have reported it to them immediately.

Inspector #692 interviewed the DOC, who identified that staff were to report all witnessed, suspected or confirmed incidents of resident abuse to senior management immediately at the time that the incident occurred to mitigate risk to residents. The DOC confirmed that the incident between RPN #107 and resident #001 was not tolerated by the home, as well as was not reported until six days after it had occurred, and it should have been reported to management immediately. [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 homes written policy to promote zero tolerance of abuse is complied with, to be implemented voluntarily.

Issued on this 9th day of September, 2019

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

Original report signed by the inspector.