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 prévue le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, L1K-0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, L1K-0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection/ Genre d'inspection
Sep 17, 2014;	2014_289550_0022 (A1)	O-001710-14	Critical Incident System

Licensee/Titulaire de permis

UNITED COUNTIES OF PRESCOTT AND RUSSELL
59 Court Street, Box 304, L'Orignal, ON, K0B-1K0

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

RESIDENCE PRESCOTT et RUSSELL
1020, Cartier Boulevard, HAWKESBURY, ON, K6A-1W7

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

JOANNE HENRIE (550) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Please note the date of compliance on the Order report has been amended to October 31st 2014.

Issued on this 17 day of September 2014 (A1)

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

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 prévue le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, L1K-0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, L1K-0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection/ Genre d'inspection
Sep 17, 2014;	2014_289550_0022 (A1)	O-001710-14	Critical Incident System

Licensee/Titulaire de permis

UNITED COUNTIES OF PRESCOTT AND RUSSELL
59 Court Street, Box 304, L'Orignal, ON, K0B-1K0

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

RESIDENCE PRESCOTT et RUSSELL
1020, Cartier Boulevard, HAWKESBURY, ON, K6A-1W7

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

JOANNE HENRIE (550) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 17 and 18, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Nursing Care supervisor, the Social Worker, several Registered nursing staff, several Personal Support Workers(PSW) and a resident.

During the course of the inspection, the inspector(s) Reviewed critical incident #M567-000009-14, a resident's health records, observed one residents' interaction with other people and reviewed the home's policy on abuse and neglect.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

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. 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 protect residents from abuse by anyone and ensure that residents are not neglected by the licensee or staff.
Physical abuse is defined by the LTCHA, 2007 as "the use of physical force by anyone other than a resident that causes physical injury or pain, administering or withholding a drug for an inappropriate purpose, or the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitement d'ordre

physique")".
Resident #001 was admitted in the home on a specific date during the first 6 months of 2014. The documentation provided to the home from the Community Care Access Centre indicates this resident was being admitted to a Long Term Care facility because he/she is physically abusive towards his/her spouse and he/she is physically abusive to him/her in reaction to his/her abuse. The nursing care supervisor indicated to Inspector #550 during an interview that Resident #001 was admitted to the home because of these issues.
Documentation in the progress notes was reviewed from a specific date in May 2014 to a specific date in July 2014 and indicated the following:
Resident #001 was out with his/her spouse on many occasions: six times in June and once in July 2014.
On a specific date in June 2014: staff observed a verbal altercation between the resident and his/her spouse.
On a specific date in June 2014: Resident #001 was observed by staff #S106 attempting to hit his/her spouse. Bruises the sizes of a toonie were observed on a specific area of the lower body of Resident #001 by staff #S106. The resident denied knowing how he/she got the bruises. During an interview, staff #S106 indicated to Inspector #550 he/she was not made aware of the previous history of abuse between Resident #001 and his/her spouse. He/she had no reasons to suspect abuse had occurred therefor he/she did not report the incident to the director.

On a specific date in June 2014: Staff #S106 observed the resident's body after his/her return from an outing with his/her spouse and there were no new bruises. The bruise on a specific area of the lower body had increased in size since the previous day.

On a specific date in June 2014: Staff #S102 assessed the resident's bruises on a specific area of the lower body. One bruise was the size of a nickel and greenish in color. The other bruise was now 10 inches long by 3 inches wide and was also greenish in color. The resident was questioned with his/her spouse and both denied knowing what happened. During the evening shift on that same day, it was documented in the progress notes by staff #S101 Resident #001 reported his/her spouse grabs and squeeze his/her wrists with a strong force and that he/she has been doing this for several years. Staff #S101 also observed bruises on upper body parts but when questioned, Resident #001 indicated to him/her those were not done by his/her spouse as he/she only does this on places where no one can see them.
There is no indication of documentation that this incident was reported to anyone.

On a specific day in June 2014: Staff #S100 documented that Resident #001 has a large bruise on a specific lower part of the body and that it appears to be old as it is yellowish in color. Resident #001 indicated to staff #S100 that his/her spouse hit him/her. Staff #S100 indicated to inspector he/she reported this incident of abuse to the nurse coordinator staff #S102 but there was no documentation in the resident's chart to support this and during an interview Staff #S102 indicated to inspector he/she had not been notified of this incident by staff #S100.

On a specific day in July 2014: The resident's physician ordered an anti-psychotic medication because Resident #001 was aggressive towards his/her spouse.

On a specific day in July 2014: Resident #001 complained of left shoulder pain to staff #S103 and indicated that it was his/her spouse who hit him/her. It was documented he/she received medication for pain and was rubbed with an analgesic cream for pain to a specific body part at 8:00, 13:00 and 22:00 on that day. The home's internal investigation report conducted by the Director of Care indicated that staff #S103 was interviewed by the Director of care to find out why he/she did not report the suspected incident of abuse to Resident #001 to anyone. Staff #S103 indicated to the Director of care that maybe he/she should have reported the incident but he/she felt he/she should wait to see if the allegations made by the resident were true.

On a specific day in July 2014: Resident #001 admitted to staff #S104 he/she scratched his/her spouse on the neck because he/she hit him/her on a specific body part. It was also documented he/she received medication for pain and was rubbed with an analgesic cream for pain at 16:00 and 20:00 on that day. The home's internal investigation report dated a specific date in July 2014 indicated that staff #S104 was interviewed by the Director of Care to find out why he/she did not report the suspected incident of abuse to Resident #001 to anyone. Staff #S104 indicated to the Director he/she was unaware this could have an impact since Resident #001 suffers from dementia.

On a specific date in July 2014: Staff #S101 documented Resident #001 returned from an outing with his/her spouse and that there were no new bruises observed. Resident indicated that his/her spouse did not touch him/her that day. Old bruises were observed on both arms and resident indicated they are the ones from last week. It was also documented in the progress notes by staff #S101 that resident complained of pain to a specific body part and was rubbed with an analgesic cream. Resident #001 indicated to this staff that his/her spouse hit him/her after he/she provoked

him/her. Staff #S101 indicated he/she informed the nurse coordinators staff #S102 and #S105 and the social worker. A copy of the e-mail dated a specific date in July 2014 was obtained and it indicated in the subject line to see the nurses notes, there was no indication of suspicions of abuse or the importance of the content of the e-mail. While at home, these staffs have access to their work e-mail through a cellular phone but they do not have access to the residents charts therefor they were unable to read the note in the chart.

On a specific date in July 2014: Resident #001 complained of pain to a specific body part, painful to touch, old bruise noted, and yellowish color. The physician was informed and ordered an analgesic x 3 days. The nurse coordinator staff #S105 was made aware of resident having pain and bruising to a specific body part. Upon a physical examination at 8:15am staff #S105 indicated observing pronounced oedema and an old bruise to a specific body part. Resident #001 experienced difficulty mobilizing that specific body part. Physician was called and resident was sent to the Hospital for an x-ray accompanied by the spouse. Resident #001 was subsequently diagnosed with a fracture of a specific body part on a specific date in July 2014. The Director of Care started an internal investigation of the incident and sent a critical incident report to the Director on July 7, 2014 at 11:13. The Hawkesbury Provincial Police was also made aware of the incident. Following the diagnosis of a fracture, the resident's physician was made aware by the Director of Care. He gave orders to put visitation restrictions in place for the resident's spouse. The spouse can only visit in public areas where they can be seen by staff. The spouse cannot be left alone with the resident.

On a specific date in 2014: it was documented by staff #S110 resident indicated his/her spouse hit him/her showing the staff how he/she used the back of his/her hand to hit him/her.

Inspector #550 interviewed Resident #001 on July 17, 2014. As per the care plan, Resident #001 has memory problems. Resident #001 is alert and a high functional resident who only requires supervision or minimal assistance for activities of daily living as per the nurse coordinator and RPN staff #S100. He/she is able to make decision regarding choices and activities of daily living. During the interview, he/she was able to orientate himself/herself around the unit and locate his/her room without assistance. He/she was alert and consistent with his/her explanation of what caused the fracture of his/her specific body part. He/she indicated to inspector #550 his/her spouse has been physically abusive for many years. He/she indicated he/she often hits him/her on this specific body part and now he/she finally broke it.

The resident's current care plan in place at the time of the above noted incidents was reviewed and it did not identify the resident's potential abuse from the spouse and his/her responsive behaviors with goals and interventions to prevent the abuse and mitigate the responsive behaviours. The Nursing Care Supervisor indicated to inspector the problem of a potential of abuse from the spouse and the responsive behaviours should be identified in the resident's written plan of care with goals and interventions to guide staff. She indicated she did not know why these issues were not identified and that it is the responsibility of the registered staff.

During an interview, the Nursing Care Supervisor indicated to Inspector #550 it is the home’s expectation that all registered staff immediately report all suspected/alleged cases of abuse/neglect to the Director using the Action Line. She indicated that a meeting was held with the Director of Care and the registered staff on April 29 and 30th, 2014 and it was explained that all registered staff are responsible of immediately notifying the Director of all suspected/alleged cases of abuse and neglect of a resident using the Action Line and that the Director of Care is responsible to submit a written report to the Director following the home’s investigation. She indicated that the above incidents were all suspected incidents of abuse of the resident by the spouse and that they should have been reported immediately to the Director and investigated immediately by the registered staff.

During an interview, PSW #S107 and PSW #S108 indicated to inspector they are aware of this resident having responsive behaviours and that there are suspicions the spouse might be physically abusing the resident. They both indicated they have never seen the spouse being physically aggressive towards the resident but have seen him/her being rough with him/her; grab him/her by the wrists and pull him/her to lead him/her and say "come on". They have never seen bruises on the resident or has he/she complained to them of being abused by him/her. They are both aware they have to report immediately any type of alleged or suspected abuse. The home's procedure is that they report to the registered staff.

There was no evidence that every alleged or suspected incidents of physical abuse involving the resident were immediately investigated (as identified in WN #4).

The licensee’s policy "Tolérance zéro d’abus et de négligence envers un résident" fails to contain an explanation of the duty under section 24 to make mandatory reports and, as per O. Reg. 79/10, 2007, section 96, the policy does not provide procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected, procedures and interventions to deal with persons

who have abused or neglected or allegedly abused or neglected residents, measures and strategies to prevent abuse and neglect, and training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations (as identified in WN #3). [s. 19. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for the resident that sets out the planned care for the resident and the goals the care is intended to achieve.
Resident #001 was admitted in the home on a specific day in the first 6 months of 2014 because of identified responsive behaviours and suspected abuse from his/her spouse. The resident's admission chart from the Community Care Access Centre was reviewed by Inspector #550 and it was indicated resident had been physically aggressive towards his/her spouse and he/she was physically aggressive towards

him/her in response to the abuse.
Inspector #550 reviewed Resident #001's current written plan of care. It did not identify the resident's responsive behaviours and the potential of abuse from the spouse with goals and interventions to prevent the abuse and mitigate the responsive behaviours.
The progress notes were reviewed from a specific date in June to a specific date in July, 2014 and the following was observed:
Incidents of responsive behaviours from Resident #001 to the spouse:
On a specific day in June: A loud verbal altercation was heard by staff from the resident's bedroom between the resident and the spouse.
On a specific day in June: Resident was observed by staff #S106 attempting to hit his/her spouse.
On a specific day in June: Resident's spouse indicated to the home's social worker his/her spouse beats him/her. Resident was observed by social worker harassing his/her spouse and verbally abused his/her spouse.
On a specific day in June: Resident was returned from an outing with the spouse accompanied by a PSW from the retirement home where the spouse lives. Resident #001 was observed by the staff at the retirement home hitting his/her spouse three times. It is documented by the resident's primary physician the resident is occasionally aggressive and occasionally hits his/her spouse.
On a specific day in June: it was documented the resident's spouse indicated to the RPN the resident was scratching him/her and he/she requested he/she was given a medication to calm him/her down.
On a specific day in June: it was documented resident was administered an antipsychotic medication as he/she was observed by staff #S103 verbally and physically aggressive towards his/her spouse.
On a specific day in July: it was documented by the resident's primary physician the resident bit his/her spouse and he adjusted his/her medication.
On a specific day in July: it was documented the resident indicated to staff #S104 he/she scratched his/her spouse because he/she hit his/her on a specific body part.
Incidents of potential abuse from the spouse to resident #001:
On a specific day in June: Bruises the sizes of a toonie were observed on a specific body part on Resident #001's lower body, by staff #S106. The resident denied knowing how he/she got the bruises.
On a specific day in June: Staff #S102 assessed the resident's bruises on his/her specific lower body part. One bruise was the size of a nickel and greenish in color. The other bruise was now 10 inches long by 3 inches wide and was also greenish in color. The resident was questioned with his/her spouse and both denied knowing what happened and denied falling. During the evening shift on that same day, it was

documented in the progress notes by staff #S101 Resident #001 reported his/her spouse grabs and squeeze his/her wrists with a strong force and that he/she's been doing this for 12 years. Staff #S101 also observed bruises on two areas of the upper body but when questioned, Resident #001 indicated to him/her those were not done by his/her spouse as he/she only does this on places where no one can see them.
On a specific day in June: Staff #S100 documented that Resident #001 has a large bruise on a specific lower body part and that it appears to be old as it is yellowish in color. Resident #001 indicated to staff #S100 that his/her spouse hit him/her.
On a specific day in July 4: Resident #001 complained of pain to a specific upper body part to staff #S103 and indicated that it was his/her spouse who hit him/her.
On a specific day in July: Resident #001 admitted to staff #S104 he/she scratched his/her spouse on the neck because he/she hit him/her on a specific upper body part.
On a specific day in July: Staff #S101 documented Resident #001 returned from an outing with his/her spouse and that there were no new bruises observed. Resident indicated that his/her spouse did not touch him/her that day. Old bruises were observed on two specific upper body parts and resident indicated they are the ones from last week. It was also documented in the progress notes by staff #S101 that resident complained of pain to a specific upper body part and was rubbed with an analgesic cream. He/she indicated to this staff that his/her spouse hit her after he/she provoked him/her.
On a specific day in July: It was documented by staff #S109 resident indicated his/her spouse fractured his/her specific upper body part.
On a specific day in July: it was documented by staff #S110 resident indicated his/her spouse hit him/her showing the staff how he/she used the back of his/her hand to hit him/her.

During an interview the Nursing Care Supervisor indicated to inspector these problems should have been identified in the resident's written plan of care with goals and clear interventions to staff to prevent the abuse and mitigate the responsive behaviours. She indicated she did not know why these issues were not identified and that it is the responsibility of the registered staff.

Order #001 has been issued under LTCHA, 2007, S.O. 2007, c.8, s. 19. Duty to protect and additional action is required. [s. 6. (1)]

WN #3: 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. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents, shall at a minimum contain an explanation of the duty under section 24 to make mandatory reports and shall deal with any additional matters as may be provided for in the regulations.

Inspector # 550 reviewed the home's zero tolerance of abuse policy titled "Tolérance zéro d'abus et de négligence envers un résidant" No: 760.03. The written policy does not contain an explanation of the duty under section 24 to make mandatory reports.

During an interview, the Nursing Care Supervisor indicated to Inspector #550 it is the home's expectation that all registered nursing staff immediately report all suspected/alleged cases of abuse/neglect to the Director using the Action Line because the PSW's are not expected to do so. She indicated that a meeting was held with the Director of Care and registered nursing staff on April 29 and 30, 2014 and it was explained that all registered nursing staff are responsible of immediately notifying

the Director of all suspected/alleged cases of abuse and neglect of a resident using the Action Line and that the Director of Care is responsible to submit a written report to the Director following the home's investigation. She indicated that the incidents of alleged/suspected abuse to Resident #001 by his/her spouse should have been reported immediately to the Director by the Registered nursing staff.

During an interview, Staff #S105 indicated to Inspector all suspected/alleged cases of abuse and neglect have to be immediately reported to the Nurse Coordinator or the Director of Care. When there is not a nurse coordinator or a Director of Care on duty in the home, the registered nursing staffs have to call the manager on call (the Director of Care or the Nursing Care Supervisor) to inform them of any suspected/alleged cases of abuse and neglect and they are the ones responsible of informing the Director.

During an interview, the home's Social Worker indicated to inspector she was unaware of when to report suspected cases of abuse of a resident and if she could do this herself.

The licensee failed to ensure that the policy deals with any additional matter. As per O. Reg. 79/10, 2007, section 96, the policy shall:
(a) Contain procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) Contain procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) Identify measures and strategies to prevent abuse and neglect; and
(e) Identify the training and retraining requirements for all staff, including, (i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and (ii) situations that may lead to abuse and neglect and how to avoid such situations.

The home's Abuse policy did not include the requirements as noted above. [s. 20. (2)]

WN #4: 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. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated: (i) Abuse of a resident by anyone.

On a specific day in June, 2014 it was documented in the progress notes that Resident #001 was observed by a registered staff to have bruises on two specific lower body parts, both are the size of a two dollar coin. Resident denies knowing the origin.

On a specific day in June, 2014 it was documented in the progress notes that the bruise on a specific lower body part is larger.

On a specific day in June 2014 it was documented in the progress notes that the nurse coordinator staff #S103 documented her observation of both bruises to two specific lower body part: one has an old bruise, yellowish color, the size of a nickel and the other one has an old bruise, greenish color, 10 inches long by 3 inches wide. She interviews the resident in front of his/her spouse and both deny knowing the cause. It is also documented in the progress notes by Staff #S101 that Resident #001 reported to him/her that his/her spouse grabs and squeeze his/her wrists with a strong force and that he/she's been doing this for several years. Staff #S101 also observed bruises on two specific upper body parts but when questioned Resident

#001 indicated to him /her his/her spouse only does this on places where no one can see them. No notes of investigation documented for this incident.

On a specific day in June RPN #S100 documented in the progress notes resident was observed with a large contusion on a specific lower body part, it appears to be an old bruise as it is yellowish. When questioned, Resident #001 indicated to staff #S100 his/her spouse hit him/her. There was no evidence that any further action was taken and there are no notes of investigation documented for this incident.

On a specific day in July, 2014 Resident #001 complained of pain to a specific upper body part. Resident #001 received an analgesic by mouth twice during the day and was also rubbed with an analgesic rub cream twice. It is documented by staff #S103 that Resident #001 indicated to him/her that his/her spouse did this to him/her but because of the resident's dementia and the fact he/she was seen by the doctor yesterday for issues of verbal abuse towards his/her spouse, he/she cannot determine if it is true therefore they will continue to question the resident. No further notes documented for that incident on this day. No notes of investigation documented for this incident.

On a specific day in July, 2014 it was documented by a RPN that Resident #001 indicated that he/she scratched his/her spouse in the neck because he/she hit him/her on a specific upper body part. No notes of investigation documented for this incident.

On a specific day in July, 2014 it was indicated in the progress notes Resident #001 indicated to a RPN that his/her spouse hit him/her on a specific upper body part but he/she had provoked him/her. No notes of investigation documented for this incident.

There are no notes of investigation documented following the resident's statement of alleged abuse by the spouse although there is documentation that the nurse coordinator and social worker were informed. The Nursing Care supervisor was unable to provide any written documentation or statement to support that an investigation had taken place following the alleged incidents of abuse on two specific date in June and three specific dates in July, 2014.
On a specific day in July, 2014: Resident #001 complained of pain to a specific upper body part, painful to touch, old bruise noted, and yellowish color. The physician was informed and ordered an analgesic to be administered by mouth, four times per day for three days. The nurse coordinator staff #S105 was made aware of resident having pain and bruising to a specific upper body part. Upon a physical examination at a specific time she indicated observing pronounced oedema and an old bruise to a

specific upper body part. Resident #001 had difficulty mobilizing a specific upper body part. Physician was called and resident was sent to the Hospital for an x-ray of a specific upper body part accompanied by his/her spouse. Resident #001 was subsequently diagnosed with a fracture to a specific upper body part on a specific day in July 2014. The Director of Care started an internal investigation of the incident and sent a critical incident report to the Director on a specific day in July 2014 at a specific time. The Hawkesbury Provincial Police was also made aware of the incident.
Following the diagnosis of a fracture to a specific upper body part, the resident's physician was made aware by the Director of Care. He gave orders to put visitation restrictions in place for the resident's spouse. The spouse can only visit in public areas where he/she can be seen by staff. He/she cannot be left alone with the resident.
A copy of the home's investigation report was given to Inspector #550 on a specific day in July 2014.

Order #001 has been issued under LTCHA, 2007, S.O. 2007, c.8, s. 19. Duty to protect and additional action is required. [s. 23. (1) (a)]

Issued on this 17 day of September 2014 (A1)

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, L1K-0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, L1K-0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : JOANNE HENRIE (550) - (A1)

Inspection No. / No de l'inspection : 2014_289550_0022 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : O-001710-14 (A1)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Sep 17, 2014;(A1)

Licensee / Titulaire de permis : UNITED COUNTIES OF PRESCOTT AND RUSSELL
59 Court Street, Box 304, L'Orignal, ON, K0B-1K0

LTC Home / Foyer de SLD : RESIDENCE PRESCOTT et RUSSELL
1020, Cartier Boulevard, HAWKESBURY, ON, K6A-1W7

Ontario

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : LOUISE LALONDE

To UNITED COUNTIES OF PRESCOTT AND RUSSELL, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

(A1)
The licensee shall prepare, submit and implement a plan to include the following:

Ensure that all staff receives education on reporting obligations of any person who has reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or risk of harm to the resident is immediately reported to the Director. Education should include that all staff do not dismiss suspicions and reporting of abuse when a resident s cognitive state is impaired or the resident has responsive behaviours.

Ensure that all incidents of suspected abuse of a resident by anyone is immediately investigated, documented and acted upon.

Develop a monitoring process to the ensure that ongoing compliance with LTCHA, 2007 S.O. 2007, c.8, s.19 (1), s. 23.(1) (a), s.6.(1) and s. 20.2.

The home's policy ''zéro tolérance d'abus et de négligence envers un résidant'' shall be revised to include all requirements as indicated in the LTCHA, 2007 S.O. 2007, c.8, s. 20. and be communicated to all staff, all department managers and social worker.

The plan shall identify the time line for completing the tasks and who will be responsible for completing those tasks.

The plan is to be submitted to Joanne Henrie by September 12, 2014 via e-mail to Joanne.Henrie@ontario.ca

Grounds / Motifs :

1. The licensee failed to protect residents from abuse by anyone and ensure that residents are not neglected by the licensee or staff.
Physical abuse is defined by the LTCHA, 2007 as "the use of physical force by anyone other than a resident that causes physical injury or pain, administering or withholding a drug for an inappropriate purpose, or the use of physical force by a resident that causes physical injury to another resident; (''mauvais traitement d'ordre physique'')".
Resident #001 was admitted in the home on a specific date during the first 6 months

of 2014. The documentation provided to the home from the Community Care Access Centre indicates this resident was being admitted to a Long Term Care facility because he/she is physically abusive towards his/her spouse and he/she is physically abusive to him/her in reaction to his/her abuse. The nursing care supervisor indicated to Inspector #550 during an interview that Resident #001 was admitted to the home because of these issues.
Documentation in the progress notes was reviewed from a specific date in May 2014 to a specific date in July 2014 and indicated the following:
Resident #001 was out with his/her spouse on many occasions: six times in June and once in July 2014.
On a specific date in June 2014: staff observed a verbal altercation between the resident and his/her spouse.
On a specific date in June 2014: Resident #001 was observed by staff #S106 attempting to hit his/her spouse. Bruises the sizes of a toonie were observed on a specific area of the lower body of Resident #001 by staff #S106. The resident denied knowing how he/she got the bruises. During an interview, staff #S106 indicated to Inspector #550 he/she was not made aware of the previous history of abuse between Resident #001 and his/her spouse. He/she had no reasons to suspect abuse had occurred therefor he/she did not report the incident to the director.

On a specific date in June 2014: Staff #S106 observed the resident's body after his/her return from an outing with his/her spouse and there were no new bruises. The bruise on a specific area of the lower body had increased in size since the previous day.

On a specific date in June 2014: Staff #S102 assessed the resident's bruises on a specific area of the lower body. One bruise was the size of a nickel and greenish in color. The other bruise was now 10 inches long by 3 inches wide and was also greenish in color. The resident was questioned with his/her spouse and both denied knowing what happened. During the evening shift on that same day, it was documented in the progress notes by staff #S101 Resident #001 reported his/her spouse grabs and squeeze his/her wrists with a strong force and that he/she has been doing this for several years. Staff #S101 also observed bruises on upper body parts but when questioned, Resident #001 indicated to him/her those were not done by his/her spouse as he/she only does this on places where no one can see them. There is no indication of documentation that this incident was reported to anyone.

On a specific day in June 2014: Staff #S100 documented that Resident #001 has a

large bruise on a specific lower part of the body and that it appears to be old as it is yellowish in color. Resident #001 indicated to staff #S100 that his/her spouse hit him/her. Staff #S100 indicated to inspector he/she reported this incident of abuse to the nurse coordinator staff #S102 but there was no documentation in the resident's chart to support this and during an interview Staff #S102 indicated to inspector he/she had not been notified of this incident by staff #S100.

On a specific day in July 2014: The resident's physician ordered an anti-psychotic medication because Resident #001 was aggressive towards his/her spouse.

On a specific day in July 2014: Resident #001 complained of left shoulder pain to staff #S103 and indicated that it was his/her spouse who hit him/her. It was documented he/she received medication for pain and was rubbed with an analgesic cream for pain to a specific body part at 8:00, 13:00 and 22:00 on that day. The home's internal investigation report conducted by the Director of Care indicated that staff #S103 was interviewed by the Director of care to find out why he/she did not report the suspected incident of abuse to Resident #001 to anyone. Staff #S103 indicated to the Director of care that maybe he/she should have reported the incident but he/she felt he/she should wait to see if the allegations made by the resident were true.

On a specific day in July 2014: Resident #001 admitted to staff #S104 he/she scratched his/her spouse on the neck because he/she hit him/her on a specific body part. It was also documented he/she received medication for pain and was rubbed with an analgesic cream for pain at 16:00 and 20:00 on that day. The home's internal investigation report dated a specific date in July 2014 indicated that staff #S104 was interviewed by the Director of Care to find out why he/she did not report the suspected incident of abuse to Resident #001 to anyone. Staff #S104 indicated to the Director he/she was unaware this could have an impact since Resident #001 suffers from dementia.

On a specific date in July 2014: Staff #S101 documented Resident #001 returned from an outing with his/her spouse and that there were no new bruises observed. Resident indicated that his/her spouse did not touch him/her that day. Old bruises were observed on both arms and resident indicated they are the ones from last week. It was also documented in the progress notes by staff #S101 that resident complained of pain to a specific body part and was rubbed with an analgesic cream. Resident #001 indicated to this staff that his/her spouse hit him/her after he/she

provoked him/her. Staff #S101 indicated he/she informed the nurse coordinators staff #S102 and #S105 and the social worker. A copy of the e-mail dated a specific date in July 2014 was obtained and it indicated in the subject line to see the nurses notes, there was no indication of suspicions of abuse or the importance of the content of the e-mail. While at home, these staffs have access to their work e-mail through a cellular phone but they do not have access to the residents charts therefor they were unable to read the note in the chart.

On a specific date in July 2014: Resident #001 complained of pain to a specific body part, painful to touch, old bruise noted, and yellowish color. The physician was informed and ordered an analgesic x 3 days. The nurse coordinator staff #S105 was made aware of resident having pain and bruising to a specific body part. Upon a physical examination at 8:15am staff #S105 indicated observing pronounced oedema and an old bruise to a specific body part. Resident #001 experienced difficulty mobilizing that specific body part. Physician was called and resident was sent to the Hospital for an x-ray accompanied by the spouse. Resident #001 was subsequently diagnosed with a fracture of a specific body part on a specific date in July 2014. The Director of Care started an internal investigation of the incident and sent a critical incident report to the Director on July 7, 2014 at 11:13. The Hawkesbury Provincial Police was also made aware of the incident. Following the diagnosis of a fracture, the resident's physician was made aware by the Director of Care. He gave orders to put visitation restrictions in place for the resident's spouse. The spouse can only visit in public areas where they can be seen by staff. The spouse cannot be left alone with the resident.

On a specific date in 2014: it was documented by staff #S110 resident indicated his/her spouse hit him/her showing the staff how he/she used the back of his/her hand to hit him/her.

Inspector #550 interviewed Resident #001 on July 17, 2014. As per the care plan, Resident #001 has memory problems. Resident #001 is alert and a high functional resident who only requires supervision or minimal assistance for activities of daily living as per the nurse coordinator and RPN staff #S100. He/she is able to make decision regarding choices and activities of daily living. During the interview, he/she was able to orientate himself/herself around the unit and locate his/her room without assistance. He/she was alert and consistent with his/her explanation of what caused the fracture of his/her specific body part. He/she indicated to inspector #550 his/her spouse has been physically abusive for many years. He/she indicated he/she often

hits him/her on this specific body part and now he/she finally broke it.
The resident's current care plan in place at the time of the above noted incidents was reviewed and it did not identify the resident's potential abuse from the spouse and his/her responsive behaviors with goals and interventions to prevent the abuse and mitigate the responsive behaviours. The Nursing Care Supervisor indicated to inspector the problem of a potential of abuse from the spouse and the responsive behaviours should be identified in the resident's written plan of care with goals and interventions to guide staff. She indicated she did not know why these issues were not identified and that it is the responsibility of the registered staff.

During an interview, the Nursing Care Supervisor indicated to Inspector #550 it is the home's expectation that all registered staff immediately report all suspected/alleged cases of abuse/neglect to the Director using the Action Line. She indicated that a meeting was held with the Director of Care and the registered staff on April 29 and 30th, 2014 and it was explained that all registered staff are responsible of immediately notifying the Director of all suspected/alleged cases of abuse and neglect of a resident using the Action Line and that the Director of Care is responsible to submit a written report to the Director following the home's investigation. She indicated that the above incidents were all suspected incidents of abuse of the resident by the spouse and that they should have been reported immediately to the Director and investigated immediately by the registered staff.

During an interview, PSW #S107 and PSW #S108 indicated to inspector they are aware of this resident having responsive behaviours and that there are suspicions the spouse might be physically abusing the resident. They both indicated they have never seen the spouse being physically aggressive towards the resident but have seen him/her being rough with him/her; grab him/her by the wrists and pull him/her to lead him/her and say "come on". They have never seen bruises on the resident or has he/she complained to them of being abused by him/her. They are both aware they have to report immediately any type of alleged or suspected abuse. The home's procedure is that they report to the registered staff.

There was no evidence that every alleged or suspected incidents of physical abuse involving the resident were immediately investigated (as identified in WN #4).

The licensee's policy "Tolérance zéro d'abus et de négligence envers un résident" fails to contain an explanation of the duty under section 24 to make mandatory reports and, as per O. Reg. 79/10, 2007, section 96, the policy does not provide

procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected, procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, measures and strategies to prevent abuse and neglect, and training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations (as identified in WN #3). [s. 19. (1)] (550)

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

Oct 31, 2014(A1)

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 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

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 17 day of September 2014 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JOANNE HENRIE

Service Area Office /
Bureau régional de services : Ottawa