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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 10, 2015	2015_289550_0001	O-000902-14, O-001086-14, O-001406-14	Follow up

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)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): January 12, 13, 14 and 15 2015.

Two inspections logs #O-001086-14 and #O-001406-14 were conducted during this inspection.

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 staff, several non-registered staff and several residents. The Inspector also reviewed the home's policy #760.03 on abuse, reviewed the education attendance list for policy #760.03 education sessions, reviewed several resident's health records, observed care and services to several residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2014_289550_0022	550

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.O. 2007, c.8, 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 has failed to ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.

On a specific date in July 2014 the licensee had reasonable doubts to suspect Resident #002 was physically assaulted by his/her spouse and had sustained a fracture to a specific part of the body as a result of this abuse.

During a follow-up inspection to the Compliance Order #001 that was issued on August 29, 2014, Inspector #550 reviewed Resident #002's current written plan of care dated a specific date in November 2014. The written plan of care did not identify the potential of abuse to Resident #002 from his/her spouse, any goals the care is intended to achieve and clear directions to staff.

During an interview, the Director of Care indicated to Inspector #550 she was not aware the potential of abuse to Resident #002 from his/her spouse should be identified in the written plan of care as she indicated the spouse is the violator and the written plan of care is for the resident. She indicated to Inspector #550 the written plan of care for Resident #002 does not provide clear directions to staff as all staff who do not regularly care for this resident would not be aware of this identified problem.

During an interview, RPN staff #S104 indicated to Inspector #550 Resident #002's written plan of care does not identify the potential of abuse to Resident #002 from his/her spouse. He/she indicated the only place this incident was documented was in the resident's progress notes at the time of the incident. He/she indicated staff who do not regularly care for this resident and new staff would not be aware of this problem and all the interventions in place to protect the resident from the suspected abuse from his/her spouse. [s. 6. (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 the written plan of care for Resident #002 is revised to include the potential of abuse to the resident from his/her spouse with interventions and goals to provide clear directions to staff who provide care to this resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 has failed to ensure that the residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

On a specific date in September 2014, the Director of Care and the Nursing Care Supervisor were informed by staff #S101, #S102 and #S103 of many incidents of alleged physical, verbal and emotional abuse towards Residents #001, #002, #003, #005 and #006 by staff #S100.

The home's internal investigation revealed that:
On many occasions in August 2014 staff #S102 was scheduled to work on the secured unit as a replacement during the summer holidays. Staff #S102 was working with staff #S100 on 5 specific dates in August. During this period of time, staff #S102 observed staff #S100 having an abusive behaviour towards different residents on different occasions and it was reported as follows:
-observed by staff #S102 pushing Resident #001's wheelchair in a sitting room using a strong force without observing where the chair would stop. Staff #S100 was then observed leaving the sitting area before the chair came to a stop at the other end of the

sitting area near the television.
- argued with Resident #001 and made an inappropriate comment telling the wheelchair bound resident "try getting out of your chair". During another argument when Resident #001 was attempting to kick staff #S100, this staff told the resident to try as much as he/she could as the resident was not able to get out of his/her chair.
-threatened Resident #001 if he/she hit staff #S100, he/she would hit him/her back even if he/she lost their job over it.
-showed the middle finger to Resident #001 on two different occasions and once to Resident #003 behind his/her back.
-walked rapidly in a threatening manner behind Resident #002 when the resident would get up often after being installed in bed in an attempt to scare the resident so the resident would stay in his/her room.
-attempted to intimidate residents during care by not smiling, the way he/she looked at them and made a comment to Resident #005 regarding the resident's weight while the resident was being transferred with the lift.

Staff #S101 observed and witnessed the following:
- on a specific date in September 18 2014, staff #S100 showed the middle finger angrily to Resident #002 in the dining room while walking towards the resident in an attempt to intimidate him/her and told the resident to eat shit. Staff #S100 later excused himself/herself to staff #S101 for his/her behaviour.
-on a specific date in September 2014, staff #S100 told staff #S101 while explaining that Resident #003 attempted to hit him/her, staff #S100 would have slugged the resident and showed staff #S101 the gesture as if the resident was in front of him/her.
-told staff #S101 "I have nothing to say to this crazy person" in front of Resident #006 when staff #S101 explained there was a translation sheet on the resident’s wheelchair to assist staff’s communication with this resident.

On a specific date in August 2014, staff #S103 observed the following:
-Staff #S100 criticized Resident #003 because the resident requested to have garlic bread.
- Staff #S100 criticized when he/she had to bring residents to the washroom.
-Staff #S100 made inappropriate comments in front of a resident who had been incontinent of urine when the incontinent product was removed and indicated he/she would no longer toilet this resident.

Inspector #550 was unable to interview Residents #001, #002, #003, #005 and #006 as they are cognitively impaired.

As of January 15, 2015 Resident #001, #002, #003, #005 and #006's substitute decision maker were not informed of the alleged incidents of abuse as identified in WN#4.

As of January 15, 2015 the police was not informed of the alleged incidents of abuse as identified in WN#5.

The incident of alleged abuse was not immediately reported to the Director as identified in WN#3.

At the time of this incident, a Compliance Order for LTCHA, 2007, s. 19 was issued on September 17, 2014 as part of inspection #2014_289550_0022, Log #O-001710-14 and had a compliance date of October 31, 2014. [s. 19. (1)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that 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:
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.

On a specific date in September 2014, staff #S101, #S102 and S103 reported several incidents of physical, verbal and emotional abuse towards Resident #001, #002, #003, #005 and #006 by staff #S100 to the Director of Care and the Nursing Care Coordinator.

These incidents of abuse were reported to the licensee on a specific date in September 2014. The licensee informed the Director of these incidents by submitting a critical incident report #M567-000017-14 the next day.

During an interview, Staff #S101 indicated to Inspector #550 that he/she did not immediately report the alleged incidents of abuse to the nurse in charge of the home at the time the incidents occurred or the supervisor as he/she wanted the opportunity to resolve these issues with the employee himself/herself because staff #S101 did not want to create animosity between him/her and staff #S100. Staff #S101 indicated he/she worked with staff #S100 on a regular basis and he/she feared reprisal from this staff member. He/she indicated that he/she discussed these issues with a co-worker staff #S102 who had worked with staff #S100 during a two week period in August 2014 and that they had decided to inform the DOC and the nursing care supervisor together because it was not right for the residents. Staff #S101 indicated he/she left a voice message to the Director of Care and the Nursing Care Supervisor indicating staff #S101 and staff #S102 wanted a meeting with them to discuss some issues on a specific week-end in September 2014. Staff #S101 did not indicate the issues were incidents of abuse.

Staff #S102 indicated to inspector he/she did not know why he/she did not immediately report the incidents to the supervisor. Staff #S102 indicated he/she discussed the issues with staff #S101 after he/she approached him/her as a friend and discussed these issues. Staff #S102 indicated he/she was afraid of staff #S100 and they decided to report the incidents together. The meeting was held on a specific date in September 2014.

During an interview, the Director of Care indicated to Inspector #550 she did not immediately report the incident of alleged abuse to the Director because she wanted to start the internal investigation and see if there was a conflict between the employees who

reported the incidents and the employee who allegedly abused the residents. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident #001, #002, #003, #005 and #006's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

On a specific date in September 2014, staff #S101, #S102 and S103 reported several incidents of physical, verbal and emotional abuse towards Resident #001, #002, #003, #005 and #006 by staff #S100 to the Director of Care and the Nursing Care Coordinator. It was reported:

Staff #S102 worked on 5 specific dates in August 2014 with staff #S100. On one of those days, staff #S102 observed that staff #S100 pushed Resident #001's wheelchair in a sitting room using a strong force without observing where the chair would stop and left the sitting area before the chair came to a stop at the other end of the sitting area near the television. Staff #S100 was observed arguing with Resident #001 and made an inappropriate comment telling the resident to "try getting out of your chair". During another argument when Resident #001 was attempting to kick staff #S100, he/she told

the resident to try as much as he/she could as the resident was not able to get out of his/her chair. Staff #S100 threatened Resident #001 if he/she hit him/her, Staff #S100 would hit the resident back even if he/she lost his/her job over it. Staff #S100 showed the middle finger to Resident #001 on two different occasions. Staff #S100 was observed walked rapidly in a threatening manner behind Resident #002 when the resident would get up often after being installed in bed in an attempt to scare the resident so he/she would stay in his/her room.

On a specific date in August 2014, staff #S103 heard staff #S100 criticizing Resident #003 when the resident requested to have garlic bread.

On a specific date in September 2014, Staff #S100 was observed by staff #S101 showing the middle finger angrily to Resident #002 in the dining room while walking towards the resident in an attempt to intimidate him/her and told the resident to eat shit. Staff #S100 indicated to staff #S101 that Resident #003 attempted to hit him/her and that he/she would have slugged the resident showing staff #S101 the gestures as if the resident was in front of him/her. On a separate occasion, Staff #S101 explained to Staff #S100 that he/she had placed a translation sheet on Resident #006's wheelchair to assist staff communicating with the resident who spoke a different language. Staff #S100 replied in front of Resident #006 "I have nothing to say to this crazy person".

During an interview, the Director of Care and the Nursing Care Supervisor indicated to Inspector #550 they had not informed the residents' substitute decision makers of the alleged incidents of abuse because they wanted to conduct their investigation first and did not want to alarm the residents' families.

On January 14, 2015 the Administrator indicated to Inspector #550 during an interview the Director of Care and the Nursing Care Supervisor should have informed the Resident's substitute decision maker of the alleged/suspected incidents of abuse as identified in the home's policy "Tolérance zéro d'abus et de négligence envers un résident et obligation de rapporter au directeur (MSSLD)".

As of January 15, 2015 Resident #001, #002, #003, #005 and #006's substitute decision maker were not informed of the alleged incidents of abuse. [s. 97. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offense.

On a specific date in September 2014, staff #S101, #S102 and S103 reported several incidents of alleged physical, verbal and emotional abuse towards Resident #001, #002, #003, #005 and #006 by staff #S100 to the Director of Care and the Nursing Care Coordinator.

During an interview, the Director of Care and the Nursing Care Supervisor both indicated to Inspector #550 that the police force was not immediately notified of the incidents of physical, verbal and emotional abuse towards Resident #001, #002, #003, #005 and #006 by staff #S100 that was reported to them on a specific date in September 2014. They both indicated to Inspector #550 they did suspect the reported incidents of abuse may constitute a criminal offense.

The incidents were reported to the Director of Care and the Nursing Care supervisor on a specific date in September 2014 and as of January 15, 2015 they were not reported to the police force. [s. 98.]

Issued on this 16th day of April, 2015

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

Original report signed by the inspector.