Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jul 28, Aug 5, 2020	2020_831211_0005	003155-20, 010703-20	Complaint

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

JOELLE TAILLEFER (211)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 22, 23, 24, 25, 29, 2020.

The following intakes were inspected:
Log # 010703-20: a complaint related to allegation of abuse, continence care, nursing and personal support services, cooling requirement, medication and reporting,
Log #003155-20: a critical incident report was included regarding misappropriation of a resident's money.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Nursing Supervisor, Services Supervisor, Services Administrative Supervisor, Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Laundry Staff, Maintenance staff, Scheduling Technician, a resident and a family member.

During the course of the inspection, the inspector reviewed identified resident's health care records, observed the provision of care and relevant policy and procedure.

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

During the course of this inspection, Non-Compliances were issued.
- **5 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	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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place a policy, the policy was complied with.

In accordance with O. Reg 79/10, s. 89 (1) (a) (iv), the licensee was required to ensure that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that there is a process to report and locate residents' lost clothing and personal items.

Specifically, staff did not comply with the licensee's policy titled "Report lost or misplaced clothing or items (Signaler les vêtements ou articles perdus ou égarés" form #780.02.01 dated on May 2016 of the home's policy #500,11. The policy indicated that the supervisor documents the follow-up on the form titled "Referral to MOHLTC and/or comment (Acheminement d'une plainte au MSSLD et/ou commentaire)" have the resident or the family member sign, and give the form to the administrative assistant so that the form can be filed in a folder for this purpose.

Review of the progress notes from an identified date, written by RN #103 indicated that resident #001 reported missing money after an employee returned their wallet.

In an interview with the Services Supervisor on an identified date, stated that the documentation sheet titled "Referral to MOHLTC and/or comment (Acheminement d'une plainte au MSSLD et/ou commentaire)" was not completed.

The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place a policy, the policy titled "Report lost or misplaced clothing or items" was complied with. [s. 8. (1) (b)]

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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place a policy, the policy was complied with, to be implemented voluntarily.

WN #2: 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 failed to 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.

On an identified date, the Ministry of Long-Term Care received a Critical Incident Report related to allegation of abuse from a staff member towards resident #001 on an identified date.

On an identified date, an email was sent by resident #001's family member indicating that a staff member abused the resident verbally and then abused their authority by removing the resident's personal item.

Review of resident #001's progress notes indicated that the police force was contacted related to the allegation of abuse towards resident #001 from a staff member four days after the licensee was notified by email from the resident's family member.

In an interview with the DOC on an identified dated confirmed that the police force was notified 4 days after receiving the abuse allegation from the resident's family member.

The licensee failed to ensure that the appropriate police force was immediately notified when they became aware on an identified date of the abuse allegation toward resident #001 from a staff member sent by email from resident #001's family member late the previous day. The police force was notified four days later. [s. 98.]

2. On an identified date, the licensee submitted a Critical Incident Report to the Ministry of Long-Term Care indicating that two days ago, there was a misuse or misappropriation of resident's money.

Review of the progress notes from an identified date written by RN #103 indicated that resident #001 reported missing money after an employee returned their wallet.

In an interview with the DOC on an identified date, stated that the police force was not contacted on the day when RN #103 was informed by the resident that money was missing from their wallet. The police force was informed two days later.

The licensee failed to ensure that the appropriate police force was immediately notified when the resident reported to RN #103 that money was missing from their wallet on an identified date. [s. 98.]

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 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 has failed to ensure that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (iii) anything else provided for in the regulation.

On an identified date, the licensee submitted a Critical Incident Report to the Ministry of Long-Term Care indicating that on an identified date, there was a misuse or misappropriation of resident's money.

Review of the progress notes from an identified date written by RN #103 indicated that resident #001 reported that money was missing after an employee returned their wallet.

In an interview with RN #103 on an identified date, stated when resident #001 complained missing money from their wallet, the complaint was not reported.

In an interview with the DOC on an identified date, stated when resident #001 reported missing money from their wallet on an identified date, RN #103 should had called the management on call. Thus, the investigation was not started until two days later.

The licensee has failed to ensure that resident #100's allegation of missing money on an identified date, that was reported to the licensee was immediately investigated. [s. 23. (1) (a) (iii)]

WN #4: 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.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to immediately report certain matters to the Director when a person who has reasonable grounds to suspect misappropriation of a resident's money.

On an identified date, the licensee submitted a Critical Incident Report to the Ministry of Long-Term Care indicating that two days earlier, there was a misuse or misappropriation of resident's money.

Review of the progress notes from an identified date written by RN #103 indicated that resident #001 reported that money was missing after an employee returned their wallet.

Review of an email written by the DOC to the Services Supervisor on an identified date indicated that three days earlier, an email was received from resident #001 alleging being robbed of an identified amount of money.

In an interview with RN #103 on an identified date, stated when resident #001 reported missing money from their wallet, the complaint was not reported immediately to the Director.

The licensee has failed to report certain matters to the Director, immediately, when RN #001 had reasonable ground to suspect misappropriation of resident #001's money on the identified date. [s. 24. (1) 4.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning an operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reason for the belief.

On an identified date, the licensee submitted a Critical Incident Report to the Ministry of Long-Term Care indicating that two days earlier, there was a misuse or misappropriation of resident's money.

Review of resident #001's progress notes written by RN #103 on an identified date, indicated that the resident reported that an employee returned their wallet found in the laundry room. The resident stated that money was missing from the wallet.

Review of emails sent by resident #001 and by the resident's family member on an identified date, indicated that the resident's wallet was found in the laundry washing machine and there was no reason for it to be in the laundry as the wallet has been in the resident dresser drawer. The paper inside the wallet was intact but money was missing.

Resident #001's progress notes written by the DOC on an identified date, indicated that an email was received from the resident alleging that money was stolen.

Interview with the DOC on an identified date, stated that a response in writing was not given to the resident after the investigation was completed.

The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the operation of the home, a response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reason for the belief.
[s. 101. (1) 3.]

Issued on this 6th day of August, 2020

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

Original report signed by the inspector.