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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 8, 2019	2019_532590_0007	018911-18, 028536-18, 029575-18, 031481-18, 032393-18, 001361-19, 002360-19, 002410-19, 002642-19, 002819-19	Critical Incident System

Licensee/Titulaire de permis

Richmond Terrace Limited
284 Central Avenue LONDON ON N6B 2C8

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

Richmond Terrace
89 Rankin Avenue AMHERSTBURG ON N9V 1E7

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

ALICIA MARLATT (590), DEBRA CHURCHER (670), JULIE DALESSANDRO (739), SAMANTHA PERRY (740)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 25 - 28 and March 1, 2019.

During the course of the inspection, the inspector(s) spoke with the Vice President of Operations and Best Practice Innovations, the Executive Director, the Director of Care, five Registered Practical Nurses, five Personal Support Workers, one Health Care Aide and one Nurses Aide.

During the course of the inspection, the inspector(s) observed infection prevention and control practices, resident rooms for specific interventions to be in place, the provision of resident care, the posting of required information, staff and resident interactions and the general maintenance and cleanliness of the home.

During the course of the inspection, the inspector(s) reviewed residents' clinical records, Critical Incident System reports, Risk Management reports and relevant policies and procedures related to inspection topics.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date. The CIS report identified that resident #006 was forcibly showered by a Personal Support Worker (PSW) at the home 16 days prior to the CIS report submission, and it was witnessed by two other PSW's who did not come forward about the witnessed abuse until the day it was reported to the MOHLTC.

Clinical record review of a progress note on a specific date was completed by Director of Care (DOC) #104 and indicated that the POA was notified of the incident which occurred 16 days prior, but was not reported to the writer until this morning. The progress note also stated that the writer had committed to calling them back as soon as the investigation was over.

A review of the home's Abuse- Prevention, Elimination, and Reporting Policy, effective date: May 2017, under subtitle- Protocol for Reporting Allegations of Resident Abuse indicated that, staff immediately report alleged, suspected or witnessed incidents to the Registered Staff member.

During an interview with DOC #104 they stated that the expectation when abuse was witnessed was that it was reported right away. They indicated that the reason it didn't happen was because the person who instigated the bath, Personal Support Worker (PSW) #112, was a union rep and senior staff member and PSW #113 and PSW #114 were intimidated by their "power". PSW #114 brought it forward to DOC #104 two weeks later.

DOC#104 confirmed that the incident with resident #006 occurred on a specific date, and was not reported to the home's management team until 16 days later. DOC #104 acknowledged that the home's policy directed staff to report incidents of abuse immediately and that the policy was not followed.

The licensee had failed to ensure that home's abuse prevention policy was complied with. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: 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 had failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director: 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.

The home submitted a CIS report to the MOHLTC on a specific date, with an occurrence date of three days prior. The CIS report was related to suspected abuse of resident #009 by resident #008.

The homes policy titled Abuse Prevention, Elimination and Reporting Policy, effective date May 2017, stated;
Protocol for Report Allegations of Resident Abuse:
-The Registered Staff member must immediately contact the Administrator, Director of Nursing or delegate.
-The Registered Staff and/or delegate will refer to the applicable decision making tree for the specific type of abuse, to use as a guide through the investigative process and for reporting and notification requirements.

During an interview with the DOC #104 they stated that the incident had occurred on a Friday, and that they had not become aware of the incident until the following Monday. The DOC stated that it was the expectation of the home that the Registered Staff would notify them after hours and on weekends and they would give direction about notification. They acknowledged that there should have been a report of the incident submitted to the MOHLTC on day of the incident.

The licensee had failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 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. [s. 24. (1)]

WN #3: 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. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that the resident and the resident's substitute decision-maker, if any, were notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

A CIS report was submitted to the MOHLTC on a specific date, with Critical Incident date and time 16 days prior to the date of the report. The CIS report identified that resident #006 was forcibly showered by a PSW at the home on a specific date, and it was witnessed by two other PSW's who did not come forward about the witnessed abuse until 16 days later. The investigation concluded 6 days after being reported to the management, and the Power of Attorney (POA) for resident #006 was not notified of the outcome until 16 days after the conclusion of the investigation, when they called the home to inquire.

Clinical record review of progress note on a specific date was completed by DOC #104 and indicated that the POA was notified of the incident which occurred 16 days earlier, but was not reported to writer until that morning. The progress note also stated that the writer had committed to calling them back as soon as the investigation was over.

Clinical record review of progress notes in Point Click Care on a specific date indicated that the POA for resident #006 called the home and asked for an update regarding the abuse allegations that involved their loved one which occurred over a month ago, and which the home's management team was made aware of approximately three weeks ago. Vice President of Operations and Best Practice Innovation #100 told the POA that the home had concluded the investigation and the staff involved had been dealt with accordingly.

A review of the home's Abuse- Prevention, Elimination, and Reporting Policy, effective date: May 2017, indicated that, the Administrator/Director of Nursing/delegate would ensure that the resident's representative/POA/Substitute Decision Maker was informed of

the incident immediately and the status of the investigation. Ideally, a Family Conference would be scheduled as soon as possible following the incident.

During an in interview with DOC #104, they stated that typically the home would complete an abuse investigation and notify the family of the outcome within ten days. DOC#104 read through the progress notes for resident #006 and recognized that the home waited sixteen days after the conclusion of the investigation to notify the family. DOC #104 confirmed that the family called the home and typically it would be the responsibility of the home to call the family. DOC#104 stated that it took too long for the family to be notified of the outcome of the investigation.

DOC#104 stated that the incident with resident #006 occurred on a specific date, and was not reported to the home's management team until 16 days later. DOC#104 also indicated that the investigation concluded on a specific date, and the family was not notified until 16 days after the conclusion of the investigation, when they called the home to inquire about the status of the investigation. DOC #104 acknowledged that the POA should have been informed immediately after the conclusion of the investigation.

The licensee had failed to ensure that the POA was notified of the outcome of the investigation immediately upon completion of the investigation. [s. 97. (2)]

Issued on this 8th day of March, 2019

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

Original report signed by the inspector.