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

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

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Inspection de soins de longue durée

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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
Jun 1, 2016	2016_290551_0009	014882-15, 020431-15, 024012-15, 010396-16	Critical Incident System

Licensee/Titulaire de permis

The Governing Council of the Salvation Army in Canada
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Long-Term Care Home/Foyer de soins de longue durée

THE SALVATION ARMY OTTAWA GRACE MANOR
1156 WELLINGTON STREET OTTAWA ON K1Y 2Z3

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

MEGAN MACPHAIL (551)

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): May 10, 11, 12, 13, 16, 17, 18, 19, 26 and 27, 2016.

Two allegations of staff to resident abuse, one allegation of resident to resident abuse and one hospitalization due to fracture were inspected.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Nursing Staff, the Manager of Human Resources, a worker from an outside agency, the Acting Director of Care (DOC) and the Executive Director.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **4 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	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. 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).

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that appropriate action is taken in response to every incident of suspected abuse.

i) On a specified date, the Ministry of Health and Long-Term Care after-hours pager was contacted to inform the Director of an incident of suspected staff to resident abuse involving resident #005 and PSW #119.

In an interview with resident #005's Substitute Decision Maker (SDM) she told the inspector that the resident had reported to her that a staff member was rough during the provision of morning care on several occasions during a two week period, and after the third time, the SDM reported it to PSW #122. Resident #005's SDM stated that the resident had referred to the PSW as brusk and rough during transfers. The SDM stated that she provided a physical description of the PSW to PSW #122, and PSW #122 said I know who that is. According to the Acting DOC, PSW #122 identified PSW #119 as the staff member.

The Acting DOC was notified of the allegation and began an investigation. On the same day, the Acting DOC sent an email to the Manager of Human Resources and the

Executive Director (ED) informing them of the allegation of abuse. The email stated that the night RN was aware of the issue and would observe closely, and then asked if she should put PSW #119 off work pending investigation. The ED's reply on the following morning was that it would be discussed after the morning meeting.

According to a review of PSW #119's schedule, the PSW worked two more scheduled shifts, was off on vacation for a month and returned to work on May 1, 2016. In May 2016, PSW #119 worked six night shifts, was off sick for three shifts, and was then put on leave pending investigation into the allegation of abuse on May 12, 2016.

According to the Manager of Human Resources, the decision to put PSW #119 off work on May 12, 2016 was based on information that was collected during the home's investigation, and the decision was made by himself and the Acting DOC. When asked why PSW #119 was not put off work after the allegation was brought forward initially, he stated that she only had one night shift to work and was then going on vacation.

According to the home's investigation file, the investigation was still ongoing as of May 18, 2016 when PSW #119 was interviewed about the allegation of abuse.

The home's policy entitled Zero Tolerance of Abuse and Neglect (# A11) states that the manager who received notification of suspected abuse has the authority to remove the staff member from their work role and to place the employee on paid administrative leave until the investigation is completed.

During an interview with the Executive Director (ED) he stated that following an allegation of abuse, Human Resources (HR) should put the staff member on leave pending investigation. The ED stated that he was under the impression that after PSW #119's shift on a specified day, she was on vacation and not providing care to residents. The ED stated that he was not aware that PSW #119 had worked six shifts in May before being put on leave pending investigation and as of May 19, 2016, he did not know the outcome of the home's investigation.

ii) During the home's investigation into an allegation of abuse involving PSW #119, resident #006 was interviewed by RN #120. An email was sent from RN #120 to the Acting DOC on a specified day and stated that resident #006 had reported that a PSW on the night shift was rough. According to the Acting DOC, the PSW was identified as PSW #119.

The Acting DOC stated that she interviewed resident #006 approximately five weeks later and that the resident denied being treated roughly by staff. Between when RN #120 made the report and the Acting DOC interviewed the resident approximately five weeks later, the Acting DOC did not know if resident #006's report of being treated roughly was investigated. [s. 23. (1) (b)]

2. The licensee has failed to ensure that the results of the abuse investigation were reported to the Director.

On a specified day, the Ministry of Health and Long-Term Care after-hours pager was contacted to inform the Director of an incident of suspected staff to resident abuse involving resident #005 and PSW #119.

The home's investigation was ongoing on May 18, 2016 when PSW #119 was interviewed by the Acting DOC and the Manager of Human Resources in the presence of a union representative.

According to the Manager of Human Resources, PSW #119 was put off work pending the home's investigation into the allegation of abuse on May 12, 2016 and was back to work on May 23, 2016.

The results of the abuse investigation were not reported to the Director as the CIR has not been updated since it was submitted. [s. 23. (2)]

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 appropriate action is taken by the licensee in response to every incident of suspected abuse, and that the results of all abuse investigations are reported to the Director, to be implemented voluntarily.

WN #2: 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 resident #003's written plan of care sets out clear directions to staff and others who provide direct care to the resident.

During interviews with RPN #103 and PSW #115 both indicated that resident #003 used to seek out resident #002.

According to progress note entries there were several documented incidents of resident #002 being displeased with resident #003 being in his/her presence. On a specified date, resident #002 said that resident #003 bothers him/her and that he/she did not want him/her in his/her room. On a specified date there was an incident of resident #003 being sexually abusive to resident #002. Resident #002 was moved to a different unit following the incident.

RPN #103 and PSW #115 stated that resident #003 has now forgotten about resident #002 and seeks out resident #007.

RPN #107 stated that resident #003 will strike resident #007 with the resident's walker and repeatedly ask if they are friends, and that resident #003 needs to be reminded that resident #007 needs personal space.

PSW #115 stated that resident #003 repeatedly asks where resident #007 is.

Resident #003's current plan of care states "Resident to maintain safe distance from co resident ([resident #002]) as previous incident of inappropriate sexual contact with resident". The plan of care does not address that resident #003 seeks out resident #007.

Resident #007's spouse stated that resident #007 likes privacy and is often disturbed by resident #003.

The Acting DOC was interviewed and stated that resident #003's plan of care should address who resident #003 is seeking out and interventions to keep them separated if it is not welcome. The Acting DOC stated that she was not aware that resident #003 was seeking out resident #007 and would address it. [s. 6. (1) (c)]

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 abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

According to O. Reg 79/10, s. 2 sexual abuse means any non-consensual touching, behaviour or remarks of a sexual nature directed towards resident by a person other than a licensee or staff.

On a specified day, resident #003 was observed by a registered practical nursing (RPN) to be touching resident #002's inappropriately in a sexual manner.

According to a progress note entry in resident #003's chart on the day of the incident, an RPN observed resident #003 leaning under the table and asked resident #002 "Do you like it?". The RPN observed resident #003 rubbing resident #002's genital area.

A Critical Incident Report (CIR) was submitted to the Director on the day of the incident. According to the CIR, the touching was non-consensual.

Resident #002's health care record was reviewed, and according to progress note entries:

Six days after the above incident, resident #002 told RN #118, who was in charge of the building, that whenever he/she passed resident #003, resident #003 said that he/she wanted to marry and have sex with resident #002. The resident was told "if the co-resident says anything like this to tell the nursing staff and we will follow up". This incident of sexual abuse was not reported to the Director.

Fifteen days after the above incident, resident #002 told RN #118, who was in charge of the building, that resident #003 was in his/her room and asked if he/she could touch the resident's genital area to which resident #002 said no. This incident of sexual abuse was not reported to the Director. [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 the resident'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 specified day, resident #002 was sexually abused by resident #003. A Critical Incident Report (CIR) was submitted to the Director on the same day as the incident occurred.

Six days after the above incident, resident #002 told RN #118, who was in charge of the building, that whenever he/she passed resident #003, resident #003 said that he/she wanted to marry and have sex with resident #002.

Fifteen days after the above incident, resident #002 told RN #118, who was in charge of the building, that resident #003 was in his/her room and asked if he/she could touch the resident's genital area to which resident #002 said no.

Resident #002's POA was notified of the last incident two days later, and there is no record of the POA being notified of the incident that occurred prior to the last. [s. 97. (1) (b)]

Issued on this 2nd day of June, 2016

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

Original report signed by the inspector.