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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 31, 2018	2018_593573_0002	010628-17, 011729-17, 012974-17, 029611-17	Critical Incident System

Licensee/Titulaire de permis

The Governing Council of the Salvation Army in Canada
2 Overlea Blvd TORONTO ON M4H 1P4

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

ANANDRAJ NATARAJAN (573)

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): January 12, 15, 16, 17, 18, 19, 22 and 23, 2018.

The following Critical Incident Logs was inspected: Critical Incident Logs #010628-17 and 029611-17 related to alleged incidents of resident to resident physical abuse. Log #012974-17, related to alleged incident of staff to resident emotional abuse. Log #011729-17, related to incident that causes an injury to a resident for which the resident is taken to hospital and that resulted in a significant change in the resident's health status.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Director of Employee Relations, the Scheduler, the Manager of external physiotherapy service provider, Physiotherapist, Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapy assistant (PTA), Personal Support Workers (PSW) and residents.

During the course of the inspection, the inspector reviewed Critical Incident (CI) reports, residents' health care record and home's internal investigation documentation. Reviewed licensee's relevant policies and procedures, In addition the inspector observed the provision of care and services to residents, observed staff to resident interactions and observed resident to resident interaction.

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.
- **2 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. 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 has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

A critical incident report (CIR) was submitted on a identified date in 2017, to the Director for an alleged staff to resident #004 emotional abuse. The CIR indicated that on identified date and time, while resident #004 was receiving one on one physiotherapy treatment, RPN #101 and PSW #102 barged into resident #004's room to proceed with the resident's care. The RPN #101 quickly undressed the resident in front of PTA #103 to provide the care. Further, the CIR indicated that resident #004 felt helpless and humiliated by the actions of the RPN #101 and PSW #102.

Resident #004 was admitted to the home with multiple diagnosis, resident #004's health care record indicated that resident required a specified care/ intervention.

During an interview with PTA #103 on January 22, 2018, it was indicated to Inspector #573 that on a identified date, when she was providing one on one physiotherapy treatment to resident #004, she witnessed RPN #101 and PSW #102 rush into resident #004's room to proceed with the resident's care. Further, PTA #103 observed resident saying "PTA is here, this is not humane, please don't take my clothes off" but the RPN proceeded with the care in the presence of PTA. The PTA witnessed that resident #004 was crying and screaming. PTA #103 indicated that she was shocked by the actions of RPN #101 and PSW #102 towards the resident.

On January 22, 2018, the licensee's Prevention of Resident Abuse or Neglect policy # A11, last review date November 2017, was reviewed by the Inspector #573. The licensee's definition of emotional abuse found on page one of the policy that indicates: "any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident"

On page five, in Mandatory Reporting under the LTCHA, the policy indicates: "Anyone, including the Home and staff members, can make immediate reports to the Director where there is a reasonable suspicion that abuse may be suspected or has occurred or may occur. Staff should immediately report under the home's staff reporting policy any incidents that may lead to a mandatory report under section 24(1)".

On January 23, 2018, during an interview, the home's DOC indicated to Inspector #573 that on a identified date and time, PTA #103 reported the alleged staff to resident emotional abuse incident which occurred on the previous day. Further the DOC indicated that an internal investigation was initiated immediately, that later confirmed emotional abuse occurred and disciplinary action was taken against RPN #101 and PSW #102. The DOC indicated to the inspector that the PTA did not report the incident immediately to her nor to the in-charge registered nurse on the same day when it occured. The DOC also indicated that the home's expectation is that staff comply with the licensee's Prevention of Resident Abuse or Neglect policy # A11.

On January 23, 2018, Inspector spoke with the home's ED who indicated that the home's physiotherapy staff were contracted staff members from an external service provider. The ED indicated that the home's expectation was that the PTA should have immediately reported the witnessed /alleged or suspected resident abuse or inappropriate care to the RN in- charge or to the member of the management team.

As such, the licensee failed to ensure that the licensee's written policy that promotes zero tolerance of abuse and neglect of residents is complied with when RPN #101 and PSW #102 forced care upon resident #004 on a specified date, resulting in resident #004 emotional abuse. Further, PTA #103 failed to comply with the licensee's Prevention of Resident Abuse or Neglect policy when the PTA did not immediately report the witnessed /alleged or suspected abuse or inappropriate care to the RN in- charge or to the member of the management team.(Log #012974-17) [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 licensee's Prevention of Resident Abuse or Neglect policy # A11 is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to comply with section 76.(4) of the Act in that the licensee failed to ensure that the persons who received training under subsection (2) receive retraining in the areas mentioned in that subsection at intervals provided for in the regulations.

In accordance with, section 76. (2) 1. 3. and 4.of the Act, and section 219. (1) of the regulation, the licensee is required to provide annual retraining of the resident bill of rights, home's policy to promote zero tolerance of abuse and neglect of residents as well as the duty under section 24 to make mandatory reports to all staff at the home.

In according to section 222. (1), Subject to subsection (2), a licensee of a long-term care home is exempt from the requirements under section 76 of the Act with respect to persons who,
(a) fall under clause (b) or (c) of the definition of "staff" in subsection 2 (1) of the Act;
(b) will only provide occasional maintenance or repair services to the home; and
(c) will not provide direct care to residents. O. Reg. 79/10, s. 222 (1).

Interviews with the home's Director of Employee Relations and DOC revealed that PSW #102 did not receive retraining annually relating to the resident bill of rights and home's policy to promote zero tolerance of abuse and neglect of residents. The Director of Employee Relations confirmed that PSW #102 last received training in the resident bill of rights and home's policy to prevent abuse and neglect of residents on November 04, 2015.

Inspector #573 spoke with the home's ED who indicated that the home's physiotherapy staff members were contracted staff from an external service provider. The ED indicated that the home's expectation was that the external physiotherapy services provider provide the training and retraining to PTA #103 related to home's policy to promote zero tolerance of abuse and neglect of residents and the duty under section 24 to make mandatory reports.

On January 22, 2018, during an interview, the Manager of external physiotherapy service provider indicated to Inspector #573 that they did not provide the annual retraining to PTA #103, specifically related to the home's policy to promote zero tolerance of abuse and neglect of residents and the duty under section 24 to make mandatory reports.(Log #012974-17) [s. 76. (4)]

Issued on this 31st day of January, 2018

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

Original report signed by the inspector.