Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jul 29, 2019	2019_782736_0015 (A1)	027299-18, 027667-18, 033142-18, 006372-19, 008458-19, 012313-19	Critical Incident System

Licensee/Titulaire de permis

Anson General Hospital
58 Anson Drive IROQUOIS FALLS ON P0K 1E0

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

South Centennial Manor
240 Fyfe Street IROQUOIS FALLS ON P0K 1E0

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

Amended by AMANDA BELANGER (736) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Health and Long-Term Care

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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*

Amendment to a date in licensee report.

Issued on this 29th day of July, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

Amended by AMANDA BELANGER (736) - (A1)

Amended 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): June 25-27, 2019.

The following intakes were inspected during this Critical Incident Inspection:

-three logs related to falls with injury;

-one log related to resident to resident abuse;

-two logs related to staff to resident abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Directors of Care, Registered Nurses(RNs), Registered Practical Nurses (RPNs) Personal Support Workers(PSWs), Physician(s), Behaviour Supports Ontario Recreational Therapist, Behavioural Supports Ontario Registered Nurse (BSO RN), housekeeper(s), scheduling coordinator, and resident(s).

During the course of the inspection, the Inspector(s) conducted a daily tour of the resident care areas, observed the provision of care, staff to resident interactions, reviewed relevant health records, internal investigation notes, employee files, staff schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of the original inspection, Non-Compliances were issued.
- **8 WN(s)**
- **3 VPC(s)**
- **5 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. 30. (1)	CO #901	2019_782736_0015	736

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. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident was restrained, or confined, in any way, for the convenience of the licensee or staff.

A Critical Incident (CI) report was submitted to the Director regarding an allegation of staff to resident abuse; whereby, it was alleged that the Director of Care (DOC) #101 had threatened to ensure that resident #004 was restrained in a specified location in the home, for an identified period of time, due to responsive behaviours being demonstrated towards the DOC and other staff.

A review of resident #004's clinical records detailed that the resident had a previous history of resident to resident abuse; and, as a result, the physician had ordered a specified intervention for the resident.

Inspector #736 reviewed resident #004's plan of care. Interventions within the plan of care advised staff that the resident was to have a specified intervention, and was to have a specified device in place. In addition, the resident was to remain in a specific location of the home, except when the specified intervention was in place, for three separate time periods during the day.

The Inspector reviewed progress notes and identified various entries that indicated that resident #004 was restrained to a specific location in the home, as there were not enough staff to provide the specified intervention. The Inspector identified a total of 14 progress notes over a six month time frame that indicated that the resident was restrained to a specific location in the home, as there was not staff available to provide the specified intervention.

In an interview with resident #004, they indicated to the Inspector that they were unable to leave a specific location in the home, unless a specified intervention was present. The resident indicated to the Inspector that they were not happy with the situation of having to stay in the specific location if a specified intervention was not available.

Inspector #736 observed the resident on specified date, for a period of ten minutes, in a specified location of the home and the specified device in place. During the observation, at a specified time, PSW #109 entered the resident's location and stated that they were ready to take the resident out. The Inspector later observed the specified location's door was closed and the specified device in place, later on the same day. PSW #109 explained to the Inspector that they had gone for their lunch, and so after resident #004 had finished in the dining room they were returned to the specified location. PSW #109 proceeded to enter the location where the resident was, and indicated that they were back from lunch, and the resident could "come out again".

In an interview with Inspector #736, PSW #109 indicated that resident #004 had a specified intervention in place for a set period of time each day; however, if the staff on the floor were short, the specified intervention would not be in place; as a result, the resident would remain in a specified location of the home until after breakfast. The PSW further explained that the resident would ring their call bell if they wanted to change locations in the home. There was specified device in place to let staff know if the resident was leaving the location. The PSW further told the Inspector that after a set time each day, the resident would return to the specified location until dinner, when a staff member would bring resident #004 to the dining room, and then return them to the specified location after dinner was completed. The PSW indicated that resident #004 was not free to move about the home without the specified intervention, but was unsure if it was considered to be a restraint. The PSW indicated that if there was no specified intervention in place, the resident was required to stay in the specified location for the duration of the day.

In an interview with Inspector #736, Registered Practical Nurse (RPN) #114 indicated that the resident had a specified intervention in place for set hours each day; however if the home was short staffed and unable to provide the specified intervention, the resident would be requested to remain in the specified location. The RPN indicated that if there was no specified intervention, resident #004 would be confined to the specified location, and there was a specified device in place to indicate to staff that the resident was attempting to exit the location. The RPN indicated that no other residents in the home were confined to any location, unless it was for isolation precautions.

In an interview with Inspector #736, staff member #111 indicated that they were aware that resident #004 had a specified intervention for set hours each day, but sometimes the home was unable to provide the intervention. The staff member indicated that when the home was not able to provide the intervention, the resident was required to stay in a specified location within the home. The staff member also indicated that after a set time, the resident was required to stay in a specified location until dinner, unless they rang the call bell and requested staff to take them for a walk. The staff member indicated to the Inspector that they felt the resident was restrained in their room when the specified intervention was not available to the resident.

In an interview with Inspector #736, Registered Nurse (RN) #112 indicated that resident #004 had a specified intervention for a set time each day. The RN indicated that if the resident did not have the specified intervention in place, they were not able to leave a specified location. The RN indicated that the resident was being restrained to the location when the specified intervention was not available. The RN indicated that after a set time each day, the resident returned to the location and was taken out for dinner and then returned back to the location for the evening. The RN indicated that the home was confining the resident to their room for staff convenience by only providing a set time period each day of the specified intervention, which was a lesser amount that what had been prescribed.

In an interview with the Inspector, Medical Doctor (MD) #115, indicated that the resident had a specified intervention for a set period of time each day, to ensure they were out of a specified location and had the opportunity to socialize. The MD indicated that it was their understanding that if the home was unable to provide the specified intervention, that resident #004 had no other choice, but to stay in a

specified location within the home. The MD further indicated that resident #004 had informed them, that this practice was very upsetting that they were confined to a specified location. The MD informed the Inspector that the home was not able to accommodate additional amounts of the specified intervention, and therefore instead of the desired amount of time each day, the home was only able to provide the resident with a lesser amount of time of the specified intervention in place each day.

In an interview with Director of Care (DOC) #105, they indicated to the Inspector that if a staff member was providing a specified intervention to a resident and required a break, they were to find another staff member to provide the intervention for the resident. The DOC indicated that the resident should not have been requested to return to a specified location in the home for the duration of the staff member's break. Together, the Inspector and DOC #105 reviewed the progress notes for resident #004, and the DOC indicated that the resident was being confined to their room for staff convenience, not as a safety measure for themselves or other residents. DOC #105 indicated that the resident only had the specified intervention for a set period of time each day due to concerns regarding costs. [s. 30. (1) 1.]

2. The licensee has failed to ensure that no resident was restrained, or confined, in any way, as a disciplinary measure.

A CI report was submitted to the Director as a result of an allegation of staff to resident abuse. Please see Written Notice (WN) #1, finding #1, for further details.

A review of resident #004's clinical records detailed that the resident had a previous history of resident to resident abuse; as a result, the physician had ordered a specified intervention for the resident.

The Inspector reviewed progress notes and identified entries that indicated that resident #004 was confined to their room as a disciplinary measure for their responsive behaviours. These progress notes were as follows:

-on a specified date, Behavioural Supports Ontario Registered Nurse (BSO RN) reviewed resident #004's responsive behaviours with DOC #101 and was informed that the resident had demonstrated responsive behaviours towards staff. The resident explained that they were frustrated by not having the specified

intervention in place and would like their "freedom reinstated." Resident #004 was made aware by DOC #101 of the plan to have the resident remain in the specified location with a specified device in place and no specified intervention, due to the resident's behaviours.
-two days later, the resident met with a staff member and DOC #101, and the resident indicated that they were unhappy that they did not have the specified intervention in place at the time and got upset when they were isolated to a specified location. The DOC indicated that the resident's schedule could be altered at any time. The DOC further told the resident that they needed to not display responsive behaviours. The resident remained upset about having to remain in the specified location.
-later on the same day, RN #117 documented that MD #115 advised DOC #101 to resume the specified intervention with resident #004 immediately. The progress note further indicated that DOC #101 had told MD #115 that resident #004's specified intervention was not present at the time due to the resident having displayed responsive behaviours towards the DOC and other staff.

The Inspector reviewed the home's internal investigation notes from the incident, which indicated that the Administrator spoke with resident #004 the day after the incident was reported to the Director. The resident explained to the Administrator that DOC #101 had stated "keep your behaviour up, and you will be locked in [a specified location] for a [duration of time]". The resident further explained that they wanted their specified intervention back so that they could walk the halls. The Administrator also spoke with RN #117, who stated that the specified intervention for resident #004 was discontinued due to resident #004 displaying responsive behaviours.

In an interview with the Inspector, resident #004 indicated that they had been upset with DOC #101, as they had removed their specified intervention and the resident was unable to leave a specified location as a result. The resident indicated that they had a verbal altercation with DOC #101 and the DOC told the resident that they would remain in the specified location for a month if their behaviour continued. The resident indicated to the Inspector that they had remained in the specified location for a duration of time, as a result of their actions towards DOC #101.

In an interview with staff member #111, they indicated to the Inspector that they had witnessed an interaction between DOC #101 and resident #004, where the resident called the DOC a "bitch" and the DOC responded by telling the resident

"keep it up and you will be in [a specified location] for a month".

The Inspector spoke with MD #115, who was the attending physician for resident #004. They indicated to the Inspector that they were made aware on a specified date, that the resident's specified intervention had been discontinued at the direction of DOC #101, due to the resident's responsive behaviours towards the DOC. The MD further indicated to the Inspector, that the resident was kept in a specified location for a period of time, as a punishment for their behaviour.

In an interview with RN #117, they indicated to the Inspector that they had been told at a shift report that DOC #101 had discontinued resident #004's specified intervention, as a result of their responsive beahviours towards staff. RN #117 indicated to the Inspector that they felt that resident #004 was being confined to a specified location as a punishment for their interactions with DOC #101.

In an interview with DOC #105, they indicated that MD #115 had made them aware of a concern regarding DOC #101 and resident #004. DOC #105 explained that the MD had been made aware that resident #004's specified intervention had been removed as a result of their interactions with DOC #101. DOC #105 and the Inspector reviewed the progress notes for resident #004 for a period of time, and DOC #105 confirmed, that based on the progress notes, resident #004 was confined to their room as a disciplinary measure. [s. 30. (1) 2.]

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision maker (SDM), if any, and any other persons designated by the resident or SDM were given an opportunity to participate fully in the development and implementation of the resident's care plan.

A CI report was submitted to the Director, for an incident that caused an injury to resident #002, which further led to the resident sustaining a significant change in health status.

A review of the progress notes indicated that on a specified date, while staff attempted to provide evening care to resident #002, they became agitated, fell, and hit a specified body part on the floor.

RN #119 had been called by PSW #107 to assess resident #002 for potential injuries. Upon assessment, the RN had documented that resident #002 had a "small" injury on the specified body part.

During an interview with Inspector #647, PSW #107 indicated they had been concerned that resident #002 had not roused at their usual time; therefore, the PSW went in to check on the resident at a specified time and found the resident had sustained a significant change in health status.

A review of the progress notes, and the post fall assessment, both indicated that the SDM and the resident's physician had not been contacted after the resident had fallen and sustained an injury. The progress notes indicated that they had only been contacted after the resident was found with a significant change in health status.

During an interview with MD #115, they indicated that they were notified by the home after the resident had been found with a significant change in health status. The MD further indicated that the home should have contacted them at the time of the fall that resulted in the injury, as well as the SDM, to allow them to participate in the plan of care and discuss transferring resident #002 to the hospital for medical intervention.

During an interview with DOC #101, they indicated that when a resident has experienced a fall that resulted in an injury, the SDM and the resident's physician were to be contacted to allow them to participate in the plan of care. The DOC had further acknowledged that RN #119 had not contacted the SDM or the MD after resident #002 had fallen. [s. 6. (5)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified.

A CI report was submitted to the Director related to resident to resident abuse. The CI report indicated that resident #004 had self disclosed to staff members that they had performed a specified act on resident #005. Resident #004 indicated that the abuse had taken place prior to reporting themselves to the staff. The CI report stated that the resident would be have a specified intervention in place to ensure resident safety.

Inspector #736 completed a review of resident #004's health records. The Inspector reviewed a doctor's order on a specified date, that indicated the resident was to have the specified intervention continued. The Inspector also viewed progress notes in the resident's chart from the date of the incident until the start of the inspection, that indicated that MD #115 wished to have the specified intervention continue for the resident.

The Inspector requested a copy of the specified intervention schedule from the date of the incident, until the time of the inspection. The Inspector noted that the

26 dates and shifts had no staff member assigned to provide the specified intervention.

In an interview with the Staffing Coordinator #121, they indicated to the Inspector that if there was no staff member name on the schedule, it indicated that there was no staff assigned to provide the specified intervention to resident #004.

During an observation on a specified date during the inspection, Inspector #736 noted that resident #004 was in their room after breakfast without the specified intervention.

In an interview with PSW #109, they indicated that they were aware that resident #004 had a specified intervention ordered. The PSW further indicated that they were assigned to provide the specified intervention to resident #004 for the date, however, was requested by the nurse to assist on the floor until after breakfast. The PSW confirmed to the Inspector that on the specified morning, the resident did not have the specified intervention as per their plan of care.

In an interview with BSO RN #112, they indicated to the Inspector, that they were aware that the MD had ordered a specified intervention of resident #004. The BSO RN further indicated to the Inspector, that they were aware of times that the specified intervention was not provided to the resident as specified in the plan of care.

In an interview with MD #115, they indicated to the Inspector that resident #004 was ordered a specified intervention for a set period of time each day; however, the home had indicated to the MD that they were not able to provide the care as ordered. The MD indicated that they were told by DOC #101 that the home could not provide the specified intervention for the set period of time each day for resident #004. The MD was further told that the home could only accommodate a lesser amount of hours of the specified intervention for resident #004. The MD indicated to the Inspector that the plan of care for resident #004 included the set period of time each day with the specified intervention.

In an interview with DOC #101, they indicated to the Inspector that the doctor's orders were considered to be part of a resident's plan of care. The DOC further indicated to the Inspector that they were aware that resident #004 had a specified intervention ordered from MD #115; however, the home was not always able to provide the care as specified. Together, the DOC and the Inspector reviewed the

schedule that was provided to the Inspector, and the DOC confirmed that on the days where there were no staff members names indicated on the schedule, care was not provided as per the resident's plan of care. [s. 6. (7)]

3. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

A CI report was submitted to the Director related to an incident of resident to resident abuse. See WN #2, finding #2, for further details.

The Inspector reviewed resident #004's clinical record and identified a progress note on a specified date, which indicated that the resident was to have a specified documentation initiated at set intervals. The Inspector identified that sections of the specified documentation at set intervals, had not occurred on on seven separate identified dates of a one month period.

In an interview with Inspector #736, PSW #118 indicated that any PSW was able to complete the specified documentation for residents. The PSW indicated that the specified documentation was to be filled out in its entirely. Together, the Inspector and the PSW reviewed the specified doucmentation for resident #004 for the period of time. The PSW confirmed that the specified documentation for resident #004 was not filled out in its entirety and should have been. The PSW indicated that care for resident #004 was not documented as set out in their plan of care.

In an interview with the Inspector, RN #120 indicated that the BSO RN and recreational therapist would typically begin the specified documentation for residents as required and let the staff on the floor know. RN #120 further indicated that the PSW who was responsible for the resident's care would be responsible for the specified documentation for the day. The RN indicated that the specified documentation was considered to be part of the resident's plan of care. Together, the Inspector and the RN reviewed resident #004's specified documentation for the period of time, and the RN confirmed that they were not filled out in their entirety. The RN confirmed to the Inspector that care was not documented as set out in the plan of care related to resident #004 and their specified charting.

In an interview with Inspector #736, DOC #101 indicated that they were unsure of the requirements related to the specified documentation for any residents.

Together, the Inspector and the DOC reviewed the specified documentation for resident #004 for the period of time. The DOC indicated to the Inspector that the specified documentation should not have been blank for periods of time. [s. 6. (9) 1.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 001

WN #3: 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 home protected residents from abuse by anyone and ensured that residents were not neglected by the licensee or staff.

For the purposes of the Act and this Regulation, "neglect" is defined as the failure to provide a resident with the treatment, care, services, or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety, or well-being of one or more residents. (O.Reg. 79/10, s.5).

a) A CI report was submitted to the Director. Please see WN #2, finding #1 for further details.

A review of the progress notes by Inspector #647, indicated that while staff attempted to provide evening care to resident #002, the resident became agitated, fell and hit an identified part of their body on the floor.

RN #119 had been called by PSW #107 to assess resident #002 for potential injuries. Upon assessment, the RN had documented that resident #002 had a "small" injury on the specified part of their body. The RN initiated a specified clinical assessment immediately after the fall.

A review of the specified clinical assessment indicated that not all assessments had been completed as follows:

-every 15 minute checks for one hour, were completed at the set intervals,
-every 30 minute checks for one hour, were scheduled at two set intervals, but were not completed, and
-every 60 minutes checks for four hours, were scheduled at four set intervals, but were not completed.

PSW #107 indicated during an interview with Inspector #647, they had been concerned that resident #002 had not roused at their usual time; therefore, the PSW went in to check on the resident after that set time hours and found the resident had sustained a significant change in health status.

Inspector #647 attempted to contact RN #119 on three occasions, but was unsuccessful. Inspector #647 reviewed the investigation notes that the home completed immediately following the incident. These investigation notes indicated that RN #119 had received disciplinary action related to the neglect of resident #002 for not completing the specified clinical assessment as scheduled, and for not contacting the physician after the resident fell.

During an interview with DOC #101, they acknowledged that RN #119 had been disciplined for neglecting resident #002 after the fall by not assessing the resident using the specified clinical assessment, and for not notifying the physician of the fall until after the resident was found to have sustained a significant change in health status.

b) 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 any strategies, the strategies were complied with.

In accordance with O. Reg. 79/10, s. 49, the licensee was required to ensure that the falls prevention and management program provided for strategies to reduce or mitigate falls, including the monitoring of the residents, and, the of review of the resident's drug regimes.

Specifically, staff did not comply with the licensee's Fall Prevention and Management Program, where it indicated that when a resident has fallen, the RN/RPN was to notify the attending physician, and SDM of the fall.

The licensee failed to ensure that the attending physician and SDM was notified of resident #002's fall as per policy; consequently, the Physician and SDM were not notified until after the resident was found to have had a significant change in health status. Please see WN #8, finding 1, for further details.

c) The Long-Term Care Homes Act, (LTCHA), 2007, c.8, s. 24, requires that the Director is notified immediately if a person has reasonable grounds to suspect that neglect of a resident by the licensee or staff that results in harm or risk of harm, has occurred.

Despite the licensee's knowledge that RN #119 had neglected resident #002, the licensee failed to notify the Director immediately. Please see WN # 7 for further details. [s. 19. (1)]

2. The licensee has failed to ensure that the home protected residents from abuse by anyone.

For the purpose of the Act and this Regulation, "verbal abuse" is defined as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes the resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident. (O.Reg. 79/10, s 2).

For the purpose of the Act and this Regulation, "emotional abuse" means 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. (O. Reg. 79.10, s. 2).

a) A CI report was submitted to the Director regarding an allegation of staff to resident abuse. Please see WN #1, finding #1, for further details.

A review of progress notes by Inspector #736, indicated that on a specified date, resident #004 was requesting to leave a specified location within the home; however, staff informed the resident that they had received a verbal order from DOC #101, that the resident was not able to leave the specified location that day or the day after. A further progress note on the same date, indicated that the resident was made aware by DOC #101 that they were required to remain in the specified location, with no specified intervention in place. The progress note indicated that the resident was upset by this. A progress note two days later, indicated that the resident was "mad" that they were isolated to a specified location in the home. The progress note went on to state that DOC #101 stated "[they] could shuffle things around which includes [the resident's] schedule when [they] needed to."

In an interview with resident #004, they recalled having been told by DOC #101 that they had to remain in a specified location because of their behaviour. They recalled the DOC indicating that once their behaviour changed, the DOC would re-instate the specified intervention for the resident. The resident stated that they did not like being required to stay in the specified location within the home, and it made them feel "bad". The resident indicated to the Inspector that they were applying for other Long Term Care homes in the area, as they no longer wished to reside in that home.

The Inspector reviewed the home's internal investigation notes, which indicated that DOC #105 had been made aware of the incident between resident #004 and DOC #101, by MD #115. The MD had contacted DOC #105, after visiting the home and finding resident #004 confined to the specified location, and learning that DOC #101 had cancelled the specified intervention that was ordered. The investigation notes further indicated that DOC #105 contacted the BSO Recreational Therapist #111, who indicated that they were present for an interaction between DOC #101 and resident #004. In the investigation notes, BSO Recreational Therapist #111 indicated to DOC #105, that DOC #101 told the resident if they kept up their behaviour, they would be in the specified location for a month.

In an interview with DOC #105, they indicated to the Inspector that after speaking with MD #115 on specified date, regarding the incident between resident #004 and DOC #101, they felt that DOC #101 had threatened resident #004.

In an interview with the Administrator, they indicated that they completed an investigation into the allegations of verbal abuse towards resident #004 by DOC #101. The Administrator further indicated, that based on their investigation, the actions of DOC #101 were abusive and against the home's policy. The Administrator indicated that the home had put processes into place to ensure that resident #004 was protected from further abuse by DOC #101, and stated "it will never happen again."

b) The LTCHA, 2007, S.O. 2007, c.8, s. 30(1) requires that every licensee of a long-term care home shall ensure that no resident of the home is restrained, in any way, as a disciplinary measure.

DOC #105 and the Inspector reviewed the progress notes for resident #004 for a period of time, and DOC #105 confirmed, that based on the progress notes, resident #004 was confined to a specified location as a disciplinary measure by DOC #101. Please see WN #1, finding #2, for further details.

c) The licensee was required to comply with the LTCHA, 2007, s. 20; which indicated that the home must comply with their internal abuse policy.

The licensee failed to ensure that their policy regarding "Zero Tolerance of Abuse and and Neglect", LTC-105, last reviewed February 2018, was complied with.

The home's policy indicated that any staff member who is suspected of resident abuse was to be suspended immediately, pending the outcome of the investigation; the home failed to do so when DOC #101 was accused of abuse of resident #004.

Please see WN #4, finding #3, for further details of non-compliance. [s. 19. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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 promoted zero tolerance of abuse and neglect of residents was complied with.

A CI report was submitted to the Director, for an allegation of staff to resident abuse. The CI report indicated that staff members overheard RN #104 indicate that resident #006 had requested a specified intervention be performed if required, and the RN did not wish to perform the specified intervention on the resident. The RN instructed the staff not to monitor resident #006. The CI report indicated that the incident took place a number of weeks prior to being reported to the Director.

Inspector #736 reviewed the internal investigation notes provided from the home and noted that DOC #101 received an email dated one day prior to the Director being notified of the allegation of staff to resident abuse, that indicated PSW #108 had heard RN #104 make abusive remarks regarding resident #006 weeks prior.

In a review of the policy titled "Zero Tolerance of Abuse and Neglect", LTC-105, last reviewed and revised February 2018, indicated that staff who had witnessed or suspected alleged incidents of resident abuse or neglect were to report the witnessed, suspected or alleged abuse to the DOC or Administrator immediately.

In separate interviews with DOC #101 and #105, they indicated to the Inspector that the home's Zero Tolerance of Abuse and Neglect policy directed staff to immediately report any allegations, witnessed or unwitnessed incidents of abuse. Both DOC #101 and #105 confirmed in separate interviews, that PSW #108 did not comply with the home's abuse policy related to immediate reporting in relation to the allegations of abuse of resident #006 by RN #104. [s. 20. (1)]

2. A CI report was submitted to the Director, for an allegation of staff to resident abuse. Please see WN #1, finding #1, for further details.

a) Inspector #736 reviewed the internal investigation notes provided from the home and noted that DOC #105 became aware of the incident on a specified date, when the after hours reporting line was contacted, although the incident had taken place two days prior.

In an interview with the Inspector, BSO Recreational Therapist #111, indicated that they had witnessed an interaction between DOC #101 and resident #004, in which the resident displayed verbal behaviours towards to the DOC. The staff member indicated to the Inspector, that the DOC told the resident that if they continued with their behaviour they would stay in a specified location for a month. The staff member acknowledged that the situation that they had witnessed made them feel uncomfortable and had upset the resident. The staff member stated that they felt it was not "the correct interaction", and therefore reported the incident to MD #115 two days after the incident, who in turn, notified DOC #105. The staff member indicated that they should have brought forward their concerns regarding the interaction immediately.

In a review of the policy titled "Zero Tolerance of Abuse and Neglect", LTC-105, last reviewed and revised February 2018, indicated that staff who had witnessed or suspected alleged incidents of resident abuse or neglect were to report the witnessed, suspected or alleged abuse to the DOC or Administrator immediately.

In an interview with DOC #105, they indicated to the Inspector that the home's "Zero Tolerance of Abuse and Neglect" policy directed staff to immediately report any allegations, witnessed or unwitnessed incidents of abuse. DOC #105 confirmed that BSO recreational therapist #111 did not comply with the home's abuse policy related to immediate reporting in relation to the allegations of verbal abuse of resident #004 by DOC #101.

b) Inspector #736 reviewed the internal investigation notes provided from the home and noted that DOC #105 had made the Administrator aware of the allegation, as soon as they became aware of the allegation of abuse of resident #004 from DOC #101. The internal investigation notes also indicated that DOC #105 had instructed the Administrator that any staff alleged of resident abuse were to be put off pending the outcome of the investigation, including DOC #101.

In a review of the policy titled "Zero Tolerance of Abuse and Neglect", LTC-105, last reviewed and revised February 2018, indicated that for staff who were accused of resident abuse, an immediate suspension would take place, pending the outcome of the investigation.

In an interview with DOC #105, they indicated to the Inspector that the home's Zero Tolerance of Abuse and Neglect policy directed the home that any time a staff member was accused of resident abuse, they were to be put off on a suspension, pending the outcome of the investigation. DOC #105 indicated that they made the Administrator aware of the requirement; however, they were aware that DOC #101 remained in the building during the investigation. DOC #105 confirmed to the Inspector, that the abuse policy was not complied with in relation to DOC #101 having remained in the building during the investigation into the allegation of verbal abuse towards resident #004.

In an interview with the Administrator, they indicated to Inspector #736, that they were aware of the home's abuse policy and confirmed that the policy indicated that employees who were accused of resident abuse were to be put off work pending the outcome of the investigation. The Administrator further explained that they felt that they had to make a judgement call, and allowed DOC #101 to remain in the building, interacting with staff and residents, during the abuse investigation. The Administrator stated that the abuse policy was not complied with "100 per cent", however, expressed that they felt that it was more beneficial to have DOC #101 remain in the home during the investigation. [s. 20. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed, and if required, a post-fall assessment had been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A CI report was submitted to the Director, for an incident that caused an injury to resident #001. Resident #001 was taken to the hospital and experienced a significant change in health status.

A review of resident #001's electronic assessments, indicated that a Head to Toe assessment had not been completed related to resident #001's fall, and a Morse fall scale had not been completed until a quarterly review had been completed, and not related to the resident's fall.

A record review of the Head to Toe assessment indicated that the registered staff member would assess the resident's head, face, eyes, ears, nose, mouth, neck, arms, hands, fingers, breasts, abdomen, back, gluteus, hips, legs, feet, and toes, immediately after each fall.

A record review of the Morse fall scale indicated that the registered staff member would document any history of falling, secondary diagnosis, ambulatory aid used,

impaired gait, and mental status.

The home's policy titled "Fall Prevention and Management Program" identified on page 3 of 32, that when a resident has fallen, the RN/RPN was to complete a Head to Toe assessment. This same policy further indicated on page 4 of 32, that a new Morse Fall scale was to be completed as soon as possible.

In an interview with Inspector #647, RPN #116 indicated that they were working when resident #001 fell. RPN #116 further indicated that when a resident falls, the registered staff member was required to complete a "Head to Toe assessment", a "MICs Long Term Care Post Fall Assessment Checklist", and a "Morse fall scale" which were all documented under the assessment tab in Point Click Care. RPN #116 indicated that the above assessments were not completed as per policy.

In an interview with DOC #101, they indicated that the Head to Toe assessment, the MICs Long Term Care Post Fall Assessment Checklist, and the Morse fall scale were all to be completed by registered staff after a resident fell, as they all captured different assessment information, and would assist in identifying fall prevention interventions. The DOC further indicated that they were unsure as to why RPN #116 did not complete them. [s. 49. (2)]

2. A CI report was submitted to the Director for an incident that caused an injury to resident #003. Following the incident, resident #003 was taken to the hospital and further resulted in a significant change in the resident's health status.

A review of the CI report identified that resident #003 had been ambulating without their walker and had a fall. Resident #003 was transferred to the hospital and diagnosed with an injury that resulted in a significant change in health status.

A review of the progress notes indicated that on the day prior, indicated that resident #003 had two falls within one hour. A review of the electronic assessments indicated that the resident did not receive a Head to Toe assessment for either of the falls that occurred on the specified date.

The home's policy titled "Fall Prevention and Management Program" identified on page 3 of 32, that when a resident falls, the RN/RPN was to complete a Head to Toe assessment.

In an interview with Inspector #647, RPN #116 indicated that they were working

when resident #003 fell. RPN #116 further indicated that when a resident falls, the Registered staff member was required to complete a "Head to Toe assessment", a "MICs Long Term Care Post Fall Assessment Checklist", and a "Morse fall scale" which were all documented under the assessment tab in Point Click Care. During the same interview, RPN #116 indicated that the above assessments were not completed.

In an interview with DOC #101, they indicated that the Head to Toe assessment, the MICs Long Term Care Post Fall Assessment Checklist, and the Morse fall scale were all to be completed by registered staff after a resident fell, as they all captured different assessment information, and was unsure why RPN #116 did not complete them. [s. 49. (2)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: 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 :

1. 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 any strategy, the strategy was complied with.

In accordance with O. Reg. 79/10, s. 49(1), the licensee was required to ensure that strategies were implemented to reduce or mitigate falls, including the monitoring of residents and the review of the residents' drug regimes.

Specifically, staff did not comply with the licensee's Fall Prevention and Management Program, last revised February 2018, to notify the resident's attending physician and SDM when a resident had sustained a fall; which is part of the licensee's Fall Prevention Program.

A CI was submitted to the Director related to an incident that caused injury to resident #002. Please see WN #2, finding #1, for further details.

A review of the progress notes indicated that while staff attempted to provide evening care to resident #002, they became agitated, and while leaving their room, they fell and hit an identified part of their body on the floor.

A review of the electronic progress notes, and the post fall assessment, both indicated that the SDM and the resident's physician had not been contacted after the resident had fallen and sustained an injury. The progress notes indicated that they had only been contacted after the resident was identified to have a significant change in health status, hours later.

The home's policy titled "Fall Prevention and Management Program" identified on page 4 of 32, that when a resident falls, the RN/RPN was to notify the attending physician, and SDM of the fall.

The Inspector interviewed DOC #101, who stated that the home's process for contacting the SDM and the attending physician had not been followed when resident #002 fell and sustained an injury. [s. 8. (1) (a),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 the home's policy titled "Fall Prevention and Management Program" is complied with, to be implemented voluntarily.

WN #7: 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 the person who had reasonable grounds to suspect that abuse or neglect of a resident had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director. Specifically; the abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

For the purposes of the Act and this Regulation, "neglect" is defined as the failure to provide a resident with the treatment, care, services, or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that

jeopardizes the health, safety, or well-being of one or more residents. (O.Reg. 79/10, s.5).

A CI report was submitted to the Director for an incident that caused an injury to resident #002, which further lead to a hospital transfer and a significant change in the resident's health status. Please see WN #2, finding #1, for further details.

A further review of the CI report did not indicate to the Director that there was any suspicion or information related to neglect of resident #002 by RN #109.

A review of the progress notes indicated that while staff attempted to provide evening care to resident #002, they became agitated, fell, and hit an identified part of their body on the floor.

RN #119 had been called by PSW #107 to assess resident #002 for potential injuries. Upon assessment, the RN had documented that resident #002 had a "small" injury to the identified part of their body. The RN initiated a specified clinical assessment after the fall.

A review of the specified clinical assessment indicated that not all assessments had been completed as follows:

-every 15 minute checks for one hour, were completed at the set intervals,
-every 30 minute checks for one hour, were scheduled at two separate intervals, were not completed, and
-every 60 minutes checks for four hours, were scheduled for four separate intervals, were not completed.

PSW #107 indicated during an interview with Inspector #647, they were concerned that resident #002 had not roused at their usual time, therefore, the PSW went in to check on the resident at a specified time and found resident had a significant change in health status.

Inspector #647 reviewed the investigation notes that the home completed immediately following the incident. The internal investigation notes indicated that RN #119 had received disciplinary action related to the neglect of resident #002 by not completing the specified clinical assessment as scheduled and for not notifying the physician.

A review of the home's policy titled "Duty to Report", last revised August 1, 2017, indicated that any alleged abuse or neglect was to be reported to the Ministry of Health and Long Term Care (MOHLTC) immediately utilizing the Critical Incident (CI) report during business hours and by utilizing the after hours number outside of business hours.

During an interview with DOC #105, they acknowledged that RN #119 had been disciplined for neglecting resident #002 after the fall by not assessing the resident using the specified clinical assessment; and for not contacting the physician until after the resident was found to have had a significant change in health status. The DOC indicated that this had not been reported as they thought that only reporting the fall was adequate and met the legislative requirements. [s. 24. (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 any person who has reasonable grounds to suspect that any neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident is reported immediately to the Director, to be implemented voluntarily.

WN #8: 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 immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that:
• resulted in a physical injury or pain to the resident, or
• caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

A CI report was submitted to the Director for an incident that caused an injury to resident #002, which further lead to a hospital transfer and a significant change in the resident's health status. Please see WN #2, finding #1, for further details.

A review of the progress notes indicated that while staff attempted to provide evening care to resident #002, they became agitated, fell, and hit an identified area of their body on the floor.

Registered Nurse #119 had been called by PSW #107 to assess resident #002 for potential injuries. Upon assessment, the RN had documented that resident #002 had a "small" injury on the identified part of their body. The RN initiated a specified clinical assessment immediately after the fall.

The internal investigation notes indicated that RN #119 had received disciplinary action related to the neglect of resident #002 by not completing the specified clinical assessment as scheduled, and for not notifying the Physician. The notes

further indicated that RN #119 had not phoned the SDM post fall, and the home had not informed the SDM that the RN had been suspended for neglect following the significant change in health status of resident #002.

During an interview with Director of Care #101, they acknowledged that RN #119 had received disciplinary action for neglecting resident #002 after the fall by not assessing the resident using the specified clinical assessment, and for not notifying the Physician. The DOC indicated that the finding of neglect towards resident #002 by RN #109 had not been reported to the SDM as they thought that only reporting the fall was adequate and met the legislative requirements. [s. 97. (1) (a)]

2. The licensee 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.

A CI report was submitted to the Director for an allegation of staff to resident verbal abuse of resident #006. Please see WN #4, finding #1, for further details.

Inspector #736 reviewed the progress notes for resident #006 in and around the time of the alleged incident. The Inspector was unable to locate any progress notes that indicated that the SDM of the resident was made aware of the allegation of verbal abuse of the resident.

A review of the policy titled "Zero Tolerance of Abuse and Neglect", LTC-105, last reviewed and revised February 2018, indicated that the SDM was to be notified within 12 hours of the home becoming aware of any incident of abuse/neglect (alleged, suspected, witnessed unwitnessed).

In an interview with DOC #101, they indicated that the home was to notify a resident's SDM immediately of an allegation of abuse towards the resident. The DOC confirmed to the Inspector that resident #006's SDM had not been notified of the allegation of verbal abuse by a staff member. The DOC indicated that the SDM of resident #006 should have been notified of the allegation of abuse. [s. 97. (1) (b)]

3. A CI report was submitted to the Director for an allegation of staff to resident verbal abuse. See WN #1, finding #1, for further details.

Inspector #736 reviewed the progress notes for resident #004 in and around the time of the alleged incident. The Inspector was unable to locate any progress notes that indicated that the SDM of the resident was made aware of the allegation of verbal abuse of the resident.

In an interview with DOC #105, they indicated that the home was to notify a resident's SDM immediately of an allegation of abuse towards the resident. The DOC confirmed to the Inspector that resident #004's SDM had not been notified of the allegation of verbal abuse by a staff member. The DOC indicated that the SDM of resident #004 should have been notified of the allegation of abuse. [s. 97. (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 a resident's SDM is notified immediately of an alleged, suspected or witnessed incident of abuse or neglect that resulted in injury to the resident, and to ensure that a resident's SDM is notified within 12 hours of an alleged, suspected or witnessed incident of abuse or neglect that did not cause injury to the resident, to be implemented voluntarily.

Issued on this 29th day of July, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by AMANDA BELANGER (736) - (A1)
Inspection No. / No de l'inspection :	2019_782736_0015 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	027299-18, 027667-18, 033142-18, 006372-19, 008458-19, 012313-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 29, 2019(A1)
Licensee / Titulaire de permis :	Anson General Hospital 58 Anson Drive, IROQUOIS FALLS, ON, P0K-1E0
LTC Home / Foyer de SLD :	South Centennial Manor 240 Fyfe Street, IROQUOIS FALLS, ON, P0K-1E0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Paul Chatelain

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To Anson General Hospital, you are hereby required to comply with the following order (s) by the date(s) set out below:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 901

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:

1. Restrained, in any way, for the convenience of the licensee or staff.
2. Restrained, in any way, as a disciplinary measure.
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36.
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Order / Ordre :

The licensee must be compliant with s. 30(1) 1 of the LTCHA.

Specifically, the licensee must immediately ensure resident #004 is not confined or restrained to any location in the home for staff convenience, including but not limited to, staff break times, and, staff shortages.

Grounds / Motifs :

1. The licensee has failed to ensure that no resident was restrained, or confined, in any way, for the convenience of the licensee or staff.

A Critical Incident (CI) report was submitted to the Director regarding an allegation of staff to resident abuse; whereby, it was alleged that the Director of Care (DOC) #101 had threatened to ensure that resident #004 was restrained to a specified location in the home, for an identified period of time, due to responsive behaviours being demonstrated towards the DOC and other staff.

A review of resident #004's clinical records detailed that the resident had a previous history of resident to resident abuse; and, as a result, the physician had ordered a specified intervention for the resident.

Inspector #736 reviewed resident #004's plan of care. Interventions within the plan of care advised staff that the resident was to have a specified intervention, and was to have a specified device in place. In addition, the resident was to remain in a specific location of the home, except when the specified intervention was in place, for three separate time periods during the day.

The Inspector reviewed progress notes and identified various entries that indicated that resident #004 was restrained to a specific location in the home, as there were not enough staff to provide the specified intervention. The Inspector identified a total of 14 progress notes over a six month time frame that indicated that the resident was restrained to a specific location in the home, as there was not staff available to provide the specified intervention.

In an interview with resident #004, they indicated to the Inspector that they were unable to leave a specific location in the home, unless a specified intervention was present. The resident indicated to the Inspector that they were not happy with the situation of having to stay in the specific location if a specified intervention was not available.

Inspector #736 observed the resident on specified date, for a period of ten minutes, in a specified location of the home and the specified device in place. During the observation, at a specified time, PSW #109 entered the resident's location and stated that they were ready to take the resident out. The Inspector later observed the specified location's door was closed and the specified device in place, later on the same day. PSW #109 explained to the Inspector that they had gone for their lunch, and so after resident #004 had finished in the dining room they were returned to the specified location. PSW #109 proceeded to enter the location where the resident was, and indicated that they were back from lunch, and the resident could "come out again".

In an interview with Inspector #736, PSW #109 indicated that resident #004 had a specified intervention in place for a set period of time each day; however, if the staff

on the floor were short, the specified intervention would not be in place; as a result, the resident would remain in a specified location of the home until after breakfast. The PSW further explained that the resident would ring their call bell if they wanted to change locations in the home. There was specified device in place to let staff know if the resident was leaving the location. The PSW further told the Inspector that after a set time each day, the resident would return to the specified location until dinner, when a staff member would bring resident #004 to the dining room, and then return them to the specified location after dinner was completed. The PSW indicated that resident #004 was not free to move about the home without the specified intervention, but was unsure if it was considered to be a restraint. The PSW indicated that if there was no specified intervention in place, the resident was required to stay in the specified location for the duration of the day.

In an interview with Inspector #736, Registered Practical Nurse (RPN) #114 indicated that the resident had a specified intervention in place for set hours each day; however if the home was short staffed and unable to provide the specified intervention, the resident would be requested to remain in the specified location. The RPN indicated that if there was no specified intervention, resident #004 would be confined to the specified location, and there was a specified device in place to indicate to staff that the resident was attempting to exit the location. The RPN indicated that no other residents in the home were confined to any location, unless it was for isolation precautions.

In an interview with Inspector #736, staff member #111 indicated that they were aware that resident #004 had a specified intervention for set hours each day, but sometimes the home was unable to provide the intervention. The staff member indicated that when the home was not able to provide the intervention, the resident was required to stay in a specified location within the home. The staff member also indicated that after a set time, the resident was required to stay in a specified location until dinner, unless they rang the call bell and requested staff to take them for a walk. The staff member indicated to the Inspector that they felt the resident was restrained in their room when the specified intervention was not available to the resident.

In an interview with Inspector #736, Registered Nurse (RN) #112 indicated that resident #004 had a specified intervention for a set time each day. The RN indicated that if the resident did not have the specified intervention in place, they were not able to leave a specified location. The RN indicated that the resident was being restrained

to the location when the specified intervention was not available. The RN indicated that after a set time each day, the resident returned to the location and was taken out for dinner and then returned back to the location for the evening. The RN indicated that the home was confining the resident to their room for staff convenience by only providing a set time period each day of the specified intervention, which was a lesser amount that what had been prescribed.

In an interview with the Inspector, Medical Doctor (MD) #115, indicated that the resident had a specified intervention for a set period of time each day, to ensure they were out of a specified location and had the opportunity to socialize. The MD indicated that it was their understanding that if the home was unable to provide the specified intervention, that resident #004 had no other choice, but to stay in a specified location within the home. The MD further indicated that resident #004 had informed them, that this practice was very upsetting that they were confined to a specified location. The MD informed the Inspector that the home was not able to accommodate additional amounts of the specified intervention, and therefore instead of the desired amount of time each day, the home was only able to provide the resident with a lesser amount of time of the specified intervention in place each day.

In an interview with Director of Care (DOC) #105, they indicated to the Inspector that if a staff member was providing a specified intervention to a resident and required a break, they were to find another staff member to provide the intervention for the resident. The DOC indicated that the resident should not have been requested to return to a specified location in the home for the duration of the staff member's break. Together, the Inspector and DOC #105 reviewed the progress notes for resident #004, and the DOC indicated that the resident was being confined to their room for staff convenience, not as a safety measure for themselves or other residents. DOC #105 indicated that the resident only had the specified intervention for a set period of time each day due to concerns regarding costs.
(736)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Immediate

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with s. 6(7) of the LTCHA.

Specifically, the licensee must

a) ensure that resident #004, and any other residents, are provided the specified intervention as per their plan of care, where directed;

b) develop and implement a process to ensure that staff are providing care as per the plan of care related to the specified intervention; and,

c) conduct audits to ensure that the care is being provided as set out in the plan of care, and maintain a record of the audits that are conducted.

Grounds / Motifs :

(A1)
1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified.

A Critical Incident (CI) report was submitted to the Director on December 21, 2018, related to resident to resident sexual abuse. The CI report indicated that resident #004 had self disclosed to staff members that they had performed a sexual act on their roommate, resident #005, while staff were attending to other residents on a night shift. Resident #004 indicated that the sexual abuse had taken place approximately three days prior to reporting themselves to the staff. The CI report stated that the resident would be placed on one to one staffing to ensure resident

safety.

Inspector #736 completed a review of resident #004's health care records. The Inspector reviewed a doctor's order dated January 2, 2019, that indicated the resident was to have one to one staffing continued. The Inspector also viewed progress notes in the resident's chart from the date of the incident until the start of the inspection, that indicated that MD #115 wished to have the one to one supervision continue for the resident;

-December 21, 2018, a progress note indicated that the MD had ordered mandatory one to one supervision.
-January 8, 2019, a progress note indicated that resident #004 had been ordered to continue with one to one supervision January 7-21, 2019, as mandatory 24 hour supervision. The progress note further indicated that staff was available, however day shift was not being covered.
-January 31, 2019, a progress note indicated that the resident was to remain on one to one supervision until a more suitable plan was established.
-February 28, 2019, a progress note indicated that the one to one support was reduced from 24 hours to 12 hours due to the resident's sleep/wake cycle.
-June 14, 2019, a progress note indicated that the resident only had one to one staffing until 1530 as per DOC #101.
-June 19, 2019, a progress note indicated that the MD instructed DOC #101 to resume one to one staffing for resident #004 immediately

The Inspector requested a copy of the one to one staffing schedule from December 21, 2018, until the time of the inspection. The Inspector noted that the following dates and shifts had no staff member assigned:
-December 22, 2018, day and night shift,
-December 23, 2018, day shift,
-December 24, 2018, day and night shift,
-December 25, 2018, day and night shift,
-December 26, 2018- January 3, 2019, day shift,
-January 6-9, 2019, day shift,
-January 11, 2019, day shift,
-May 20-23, 2019, day shift.

In an interview with the Staffing Coordinator #121, they indicated to the Inspector that

if there was no staff member name on the schedule, it indicated that there was no one to one staffing assigned to resident #004.

During an observation on June 26, 2019, Inspector #736 noted that resident #004 was in their room after breakfast without one to one supervision.

In an interview with PSW #109, they indicated that they were aware that resident #004 had one to one staffing ordered. The PSW further indicated that they were assigned to provide one to one supervision to resident #004 for June 26, 2019, however, was requested by the nurse to assist on the floor until after breakfast. The PSW confirmed to the Inspector that on the morning of June 26, 2019, the resident did not have one to one staffing as per their plan of care.

In an interview with BSO RN #112, they indicated to the Inspector, that they were aware that the MD had ordered one to one supervision of resident #004. The BSO RN further indicated to the Inspector, that they were aware of times that the one to one staffing was not provided to the resident as specified in the plan of care.

In an interview with MD #115, they indicated to the Inspector that resident #004 was ordered 12 hours per day of one to one staffing; however, the home had indicated to the MD that they were not able to provide the care as ordered. The MD indicated that they were told by DOC #101 that the home could not provide 12 hours per day of one to one supervision for resident #004. The MD was further told that the home could only accommodate eight hours per day of one to one staffing for resident #004. The MD indicated to the Inspector that the plan of care for resident #004 included 12 hours of one to one supervision per day.

In an interview with DOC #101, they indicated to the Inspector that the doctor's orders were considered to be part of a resident's plan of care. The DOC further indicated to the Inspector that they were aware that resident #004 had one to one staffing ordered from MD #115; however, the home was not always able to provide the care as specified. Together, the DOC and the Inspector reviewed the observation schedule that was provided to the Inspector, and the DOC confirmed that on the days where there were no staff members names indicated on the schedule, care was not provided as per the resident's plan of care.

The severity of this issue was determined to be a three, as there was actual risk to

the resident. The scope of the issue was a level one or isolated, as it only applied to one resident identified. The home had a level three compliance history, as they had related non-compliance with this section of the Ontario Regulation 79/10 that included:
-a voluntary plan of correction (VPC) issued February 22, 2018 (#2019_624196_0001). (736)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 10, 2019

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 19(1) of the LTCHA.

Specifically, the licensee must ensure that all residents are protected from abuse by anyone, and shall ensure that residents are not neglected by the licensee or staff.

Grounds / Motifs :

1. The licensee has failed to ensure that the home protected residents from abuse by anyone and ensured that residents were not neglected by the licensee or staff.

For the purposes of the Act and this Regulation, "neglect" is defined as the failure to provide a resident with the treatment, care, services, or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety, or well-being of one or more residents. (O.Reg. 79/10, s.5).

a) A CI report was submitted to the Director. Please see WN #2, finding #1 for further details.

A review of the progress notes by Inspector #647, indicated that while staff attempted to provide evening care to resident #002, the resident became agitated, fell and hit an identified part of their body on the floor.

RN #119 had been called by PSW #107 to assess resident #002 for potential injuries. Upon assessment, the RN had documented that resident #002 had a “small"

injury on the specified part of their body. The RN initiated a specified clinical assessment immediately after the fall.

A review of the specified clinical assessment indicated that not all assessments had been completed as follows:

-every 15 minute checks for one hour, were completed at the set intervals,
-every 30 minute checks for one hour, were scheduled at two set intervals, but were not completed, and
-every 60 minutes checks for four hours, were scheduled at four set intervals, but were not completed.

PSW #107 indicated during an interview with Inspector #647, they had been concerned that resident #002 had not roused at their usual time; therefore, the PSW went in to check on the resident after that set time hours and found the resident had sustained a significant change in health status.

Inspector #647 attempted to contact RN #119 on three occasions, but was unsuccessful. Inspector #647 reviewed the investigation notes that the home completed immediately following the incident. These investigation notes indicated that RN #119 had received disciplinary action related to the neglect of resident #002 for not completing the specified clinical assessment as scheduled, and for not contacting the physician after the resident fell.

During an interview with DOC #101, they acknowledged that RN #119 had been disciplined for neglecting resident #002 after the fall by not assessing the resident using the specified clinical assessment, and for not notifying the physician of the fall until after the resident was found to have sustained a significant change in health status.

b) 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 any strategies, the strategies were complied with.

In accordance with O. Reg. 79/10, s. 49, the licensee was required to ensure that the falls prevention and management program provided for strategies to reduce or mitigate falls, including the monitoring of the residents, and, the of review of the

resident's drug regimes.

Specifically, staff did not comply with the licensee's Fall Prevention and Management Program, where it indicated that when a resident has fallen, the RN/RPN was to notify the attending physician, and SDM of the fall.

The licensee failed to ensure that the attending physician and SDM was notified of resident #002's fall as per policy; consequently, the Physician and SDM were not notified until after the resident was found to have had a significant change in health status. Please see WN #8, finding 1, for further details.

c) The Long-Term Care Homes Act, (LTCHA), 2007, c.8, s. 24, requires that the Director is notified immediately if a person has reasonable grounds to suspect that neglect of a resident by the licensee or staff that results in harm or risk of harm, has occurred.

Despite the licensee's knowledge that RN #119 had neglected resident #002, the licensee failed to notify the Director immediately. Please see WN # 7 for further details.
(647)

2. The licensee has failed to ensure that the home protected residents from abuse by anyone.

For the purpose of the Act and this Regulation, "verbal abuse" is defined as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes the resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident. (O.Reg. 79/10, s 2).

For the purpose of the Act and this Regulation, "emotional abuse" means 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. (O. Reg. 79.10, s. 2).

a) A CI report was submitted to the Director regarding an allegation of staff to resident abuse. Please see WN #1, finding #1, for further details.

A review of progress notes by Inspector #736, indicated that on a specified date, resident #004 was requesting to leave a specified location within the home; however, staff informed the resident that they had received a verbal order from DOC #101, that the resident was not able to leave the specified location that day or the day after. A further progress note on the same date, indicated that the resident was made aware by DOC #101 that they were required to remain in the specified location, with no specified intervention in place. The progress note indicated that the resident was upset by this. A progress note two days later, indicated that the resident was "mad" that they were isolated to a specified location in the home. The progress note went on to state that DOC #101 stated "[they] could shuffle things around which includes [the resident's] schedule when [they] needed to."

In an interview with resident #004, they recalled having been told by DOC #101 that they had to remain in a specified location because of their behaviour. They recalled the DOC indicating that once their behaviour changed, the DOC would re-instate the specified intervention for the resident. The resident stated that they did not like being required to stay in the specified location within the home, and it made them feel "bad". The resident indicated to the Inspector that they were applying for other Long Term Care homes in the area, as they no longer wished to reside in that home.

The Inspector reviewed the home's internal investigation notes, which indicated that DOC #105 had been made aware of the incident between resident #004 and DOC #101, by MD #115. The MD had contacted DOC #105, after visiting the home and finding resident #004 confined to the specified location, and learning that DOC #101 had cancelled the specified intervention that was ordered. The investigation notes further indicated that DOC #105 contacted the BSO Recreational Therapist #111, who indicated that they were present for an interaction between DOC #101 and resident #004. In the investigation notes, BSO Recreational Therapist #111 indicated to DOC #105, that DOC #101 told the resident if they kept up their behaviour, they would be in the specified location for a month.

In an interview with DOC #105, they indicated to the Inspector that after speaking with MD #115 on specified date, regarding the incident between resident #004 and DOC #101, they felt that DOC #101 had threatened resident #004.

In an interview with the Administrator, they indicated that they completed an

investigation into the allegations of verbal abuse towards resident #004 by DOC #101. The Administrator further indicated, that based on their investigation, the actions of DOC #101 were abusive and against the home's policy. The Administrator indicated that the home had put processes into place to ensure that resident #004 was protected from further abuse by DOC #101, and stated "it will never happen again."

b) The LTCHA, 2007, S.O. 2007, c.8, s. 30(1) requires that every licensee of a long-term care home shall ensure that no resident of the home is restrained, in any way, as a disciplinary measure.

DOC #105 and the Inspector reviewed the progress notes for resident #004 for a period of time, and DOC #105 confirmed, that based on the progress notes, resident #004 was confined to a specified location as a disciplinary measure by DOC #101. Please see WN #1, finding #2, for further details.

c) The licensee was required to comply with the LTCHA, 2007, s. 20; which indicated that the home must comply with their internal abuse policy.

The licensee failed to ensure that their policy regarding "Zero Tolerance of Abuse and and Neglect", LTC-105, last reviewed February 2018, was complied with.

The home's policy indicated that any staff member who is suspected of resident abuse was to be suspended immediately, pending the outcome of the investigation; the home failed to do so when DOC #101 was accused of abuse of resident #004.

Please see WN #4, finding #3, for further details of non-compliance.

The severity of this issue was determined to be a three, as there was actual harm to the residents. The scope of the issue was a level two, identified as a pattern. The home had a level two compliance history, with one or more unrelated non-compliances in the last 36 months.
(736)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 18, 2019

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 20(1) of the LTCHA.

Specifically, the licensee must

a) ensure that all staff comply with the "Zero Tolerance of Abuse and Neglect" policy related to reporting allegations of abuse and/or neglect;

b) ensure that staff comply with the section of the policy, specifically, related to staff accused of abuse or neglect of a resident;

c) retrain all direct care staff, including the management team, on the policy related to Zero Tolerance of Abuse and Neglect policy;

d) keep records related to staff training, including the date the training was provided, who provided the training, what was covered, and who attended the training.

Grounds / Motifs :

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

A CI report was submitted to the Director, for an allegation of staff to resident abuse. The CI report indicated that staff members overheard RN #104 indicate that resident #006 had requested a specified intervention be performed if required, and the RN did not wish to perform the specified intervention on the resident. The RN instructed the staff not to monitor resident #006. The CI report indicated that the incident took place a number of weeks prior to being reported to the Director.

Inspector #736 reviewed the internal investigation notes provided from the home and noted that DOC #101 received an email dated one day prior to the Director being notified of the allegation of staff to resident abuse, that indicated PSW #108 had heard RN #104 make abusive remarks regarding resident #006 weeks prior.

In a review of the policy titled "Zero Tolerance of Abuse and Neglect", LTC-105, last reviewed and revised February 2018, indicated that staff who had witnessed or suspected alleged incidents of resident abuse or neglect were to report the witnessed, suspected or alleged abuse to the DOC or Administrator immediately.

In separate interviews with DOC #101 and #105, they indicated to the Inspector that the home's Zero Tolerance of Abuse and Neglect policy directed staff to immediately report any allegations, witnessed or unwitnessed incidents of abuse. Both DOC #101 and #105 confirmed in separate interviews, that PSW #108 did not comply with the home's abuse policy related to immediate reporting in relation to the allegations of abuse of resident #006 by RN #104. [s. 20. (1)] (736)

2. A CI report was submitted to the Director, for an allegation of staff to resident abuse. Please see WN #1, finding #1, for further details.

a) Inspector #736 reviewed the internal investigation notes provided from the home and noted that DOC #105 became aware of the incident on a specified date, when the after hours reporting line was contacted, although the incident had taken place two days prior.

In an interview with the Inspector, BSO Recreational Therapist #111, indicated that they had witnessed an interaction between DOC #101 and resident #004, in which the resident displayed verbal behaviours towards to the DOC. The staff member

indicated to the Inspector, that the DOC told the resident that if they continued with their behaviour they would stay in a specified location for a month. The staff member acknowledged that the situation that they had witnessed made them feel uncomfortable and had upset the resident. The staff member stated that they felt it was not "the correct interaction", and therefore reported the incident to MD #115 two days after the incident, who in turn, notified DOC #105. The staff member indicated that they should have brought forward their concerns regarding the interaction immediately.

In a review of the policy titled "Zero Tolerance of Abuse and Neglect", LTC-105, last reviewed and revised February 2018, indicated that staff who had witnessed or suspected alleged incidents of resident abuse or neglect were to report the witnessed, suspected or alleged abuse to the DOC or Administrator immediately.

In an interview with DOC #105, they indicated to the Inspector that the home's "Zero Tolerance of Abuse and Neglect" policy directed staff to immediately report any allegations, witnessed or unwitnessed incidents of abuse. DOC #105 confirmed that BSO recreational therapist #111 did not comply with the home's abuse policy related to immediate reporting in relation to the allegations of verbal abuse of resident #004 by DOC #101.

b) Inspector #736 reviewed the internal investigation notes provided from the home and noted that DOC #105 had made the Administrator aware of the allegation, as soon as they became aware of the allegation of abuse of resident #004 from DOC #101. The internal investigation notes also indicated that DOC #105 had instructed the Administrator that any staff alleged of resident abuse were to be put off pending the outcome of the investigation, including DOC #101.

In a review of the policy titled "Zero Tolerance of Abuse and Neglect", LTC-105, last reviewed and revised February 2018, indicated that for staff who were accused of resident abuse, an immediate suspension would take place, pending the outcome of the investigation.

In an interview with DOC #105, they indicated to the Inspector that the home's Zero Tolerance of Abuse and Neglect policy directed the home that any time a staff member was accused of resident abuse, they were to be put off on a suspension, pending the outcome of the investigation. DOC #105 indicated that they made the

Administrator aware of the requirement; however, they were aware that DOC #101 remained in the building during the investigation. DOC #105 confirmed to the Inspector, that the abuse policy was not complied with in relation to DOC #101 having remained in the building during the investigation into the allegation of verbal abuse towards resident #004.

In an interview with the Administrator, they indicated to Inspector #736, that they were aware of the home's abuse policy and confirmed that the policy indicated that employees who were accused of resident abuse were to be put off work pending the outcome of the investigation. The Administrator further explained that they felt that they had to make a judgement call, and allowed DOC #101 to remain in the building, interacting with staff and residents, during the abuse investigation. The Administrator stated that the abuse policy was not complied with "100 per cent", however, expressed that they felt that it was more beneficial to have DOC #101 remain in the home during the investigation.

The severity of this issue was determined to be a two, as there was minimal harm or minimal risk to the residents. The scope of the issue was a level three, widespread, as it applied to three incidents identified. The home had a level three compliance history, as they had related non-compliance with this section of the Ontario Regulation 79/10 that included:
-a written notice (WN) issued February 22, 2018 (#2018_624196_0001). (736)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 10, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 004

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Order / Ordre :

The licensee must be compliant with O.Reg. s. 49(2).

Specifically, the license must ensure that:

a) all residents who have fallen are assessed, and if required, a post-fall assessment is conducted using a clinically appropriate assessment tool specifically designed for falls;

b) ensure that RPN #116 receives re-training related to the home's Fall Prevention and Management Program; and,

c) create and implement an audit tool, which includes the dates of the audits, who completed the audits, and actions taken to correct deficiencies, related to post-fall assessments being completed for residents who have fallen.

Grounds / Motifs :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed, and if required, a post-fall assessment had been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A CI report was submitted to the Director, for an incident that caused an injury to resident #001. Resident #001 was taken to the hospital and experienced a significant change in health status.

A review of resident #001's electronic assessments, indicated that a Head to Toe assessment had not been completed related to resident #001's fall, and a Morse fall scale had not been completed until a quarterly review had been completed, and not related to the resident's fall.

A record review of the Head to Toe assessment indicated that the registered staff member would assess the resident's head, face, eyes, ears, nose, mouth, neck, arms, hands, fingers, breasts, abdomen, back, gluteus, hips, legs, feet, and toes, immediately after each fall.

A record review of the Morse fall scale indicated that the registered staff member would document any history of falling, secondary diagnosis, ambulatory aid used, impaired gait, and mental status.

The home's policy titled "Fall Prevention and Management Program" identified on page 3 of 32, that when a resident has fallen, the RN/RPN was to complete a Head to Toe assessment. This same policy further indicated on page 4 of 32, that a new Morse Fall scale was to be completed as soon as possible.

In an interview with Inspector #647, RPN #116 indicated that they were working when resident #001 fell. RPN #116 further indicated that when a resident falls, the registered staff member was required to complete a "Head to Toe assessment", a "MICs Long Term Care Post Fall Assessment Checklist", and a "Morse fall scale" which were all documented under the assessment tab in Point Click Care. RPN #116 indicated that the above assessments were not completed as per policy.

In an interview with DOC #101, they indicated that the Head to Toe assessment, the MICs Long Term Care Post Fall Assessment Checklist, and the Morse fall scale were all to be completed by registered staff after a resident fell, as they all captured different assessment information, and would assist in identifying fall prevention interventions. The DOC further indicated that they were unsure as to why RPN #116 did not complete them. (736)

2. A CI report was submitted to the Director for an incident that caused an injury to resident #003. Following the incident, resident #003 was taken to the hospital and further resulted in a significant change in the resident's health status.

A review of the CI report identified that resident #003 had been ambulating without their walker and had a fall. Resident #003 was transferred to the hospital and diagnosed with an injury that resulted in a significant change in health status.

A review of the progress notes indicated that on the day prior, indicated that resident #003 had two falls within one hour. A review of the electronic assessments indicated that the resident did not receive a Head to Toe assessment for either of the falls that occurred on the specified date.

The home's policy titled "Fall Prevention and Management Program" identified on page 3 of 32, that when a resident falls, the RN/RPN was to complete a Head to Toe assessment.

In an interview with Inspector #647, RPN #116 indicated that they were working when resident #003 fell. RPN #116 further indicated that when a resident falls, the Registered staff member was required to complete a "Head to Toe assessment", a "MICs Long Term Care Post Fall Assessment Checklist", and a "Morse fall scale" which were all documented under the assessment tab in Point Click Care. During the same interview, RPN #116 indicated that the above assessments were not completed.

In an interview with DOC #101, they indicated that the Head to Toe assessment, the MICs Long Term Care Post Fall Assessment Checklist, and the Morse fall scale were all to be completed by registered staff after a resident fell, as they all captured different assessment information, and was unsure why RPN #116 did not complete them.

The severity of this issue was determined to be a two, as there was actual harm or actual risk to the resident. The scope of the issue was a level two, or pattern. The home had a level three compliance history, as they had related non-compliance with this section of the Ontario Regulation 79/10 that included:
-a WN issued October 23, 2017 (#2017_669642_0016). (736)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Sep 10, 2019

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 29th day of July, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by AMANDA BELANGER (736) - (A1)

Order(s) of the Inspector

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Service Area Office / Bureau régional de services : Sudbury Service Area Office