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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 11, 2019	2019_617148_0017	032487-18, 000681-19	Critical Incident System

Licensee/Titulaire de permis

The Religious Hospitallers of St. Joseph of Cornwall, Ontario
14 York St CORNWALL ON K6J 5T2

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

St. Joseph's Continuing Care Centre
14 York Street CORNWALL ON K6J 5T2

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

AMANDA NIXON (148)

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 5, 6, 7, 10, 11 and 12, 2019

This inspection included two critical incident reports (CIR): Log 032487-18 (CIR #C565-000021-18) related to alleged staff to resident verbal abuse and Log 000681-19 (CIR #C565-000002-19) related to an incident that caused injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Chief Nursing Officer (CNO), Nursing Administrative Assistant, Resident Care Aides (RCA), RCA Supervisor, Registered Practical Nurses, Occupational Therapist, Occupational Therapy Assistant, Director of Therapy Services, Health Services and Human Resources Assistant, Health, Safety and Education Coordinator and residents.

In addition, the Inspector reviewed resident health care records, staffing schedules, relevant policies and procedures related to the prevention of abuse and neglect of residents and documents related to the training of staff on the prevention of abuse and neglect of residents. The Inspector also observed the resident care environment, resident care and staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident’s money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident, has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

In accordance with section 2 of O. Regulation 79/10, verbal abuse means, 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 a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A critical incident report was submitted to the Director on a specified date, describing that 14 days prior, RCA #115 witnessed RCA #116 scolding and swearing at resident #001. In an interview with RCA #115 it was reported to the Inspector that when providing care to resident #001, RCA #116 swore at the resident, called the resident names and scolded the resident. RCA #115 described the resident as shaking and crying during the incident. RCA #115 reported the incident to the RCA Supervisor 14 days after the incident.

As it relates to the described incident, the alleged abuse was not reported immediately to the Director.
(Log 032487-18) [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 a person who has reasonable grounds to suspect that 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, has occurred or may occur immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002 was treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

On a specified date, OT #113 implemented the use of a 4 point lap belt as a physical restraint for resident #002.

On the morning of June 6, 2019, Inspector #148 observed resident #002. The resident was seated with a lap belt applied under the resident's clothing. The open back clothing was draped over the resident's front body as the clothing was not secured in the back. The resident's incontinence product and bare flesh were visible between the seat cushion and back rest of the chair.

The Inspector spoke with two day shift RCAs, #103 and #104, who indicated that the resident was dressed and transferred to the wheelchair by night staff. The RCAs reported that the position of the lap belt under the clothing was due to the resident's tendency to touch the lap belt and possibly release the lap belt. The Inspector reported the observation of the incontinence product and bare flesh to be visible, to which the RCAs were aware. In an interview with the night shift RCA #114, who had provided the resident with morning care June 6 and 7, 2019, the RCA indicated that the application of the lap belt under the clothing was to prevent the resident from taking the lap belt off.

On a subsequent observation on June 7, 2019, the resident was observed with the lap belt applied under the clothing. During this observation it was noted that the resident's chair had been provided with the addition of a privacy curtain that covered the gap existing between the chair cushion and back rest; the resident's incontinence product was no longer visible. The addition of the privacy curtain was completed the afternoon of June 6, 2019, by therapy services after the RCA Supervisor had overheard day shift RCAs discussing the resident and the matter of the lap belt and exposure of incontinence product.

Resident #002 was not treated with courtesy and respect and in a way that fully respects the resident's dignity, as it relates to dressing and application of a physical restraint. (Log 000681-19) [s. 3. (1) 1.]

WN #3: 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).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

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

The policy to promote zero tolerance of abuse and neglect of residents was identified as the Zero Tolerance of Abuse and/or Neglect of Residents and Patients, revision date of November 7, 2018.

The policy described that all employees and affiliated personnel are to report any alleged

incident of resident/patient abuse immediately to their Manager/Designate.

A critical incident report was submitted to the Director on a specified date, describing that 14 days prior, RCA #115 witnessed RCA #116 scolding and swearing at resident #001. In an interview with RCA #115 it was reported to the Inspector that when providing care to resident #001, RCA #116 swore at the resident, called the resident names and scolded the resident. RCA #115 described the resident as shaking and crying during the incident. RCA #115 reported the incident to the RCA Supervisor 14 days after the incident.

In this way, RCA #115 did not comply with the policy to promote zero tolerance of abuse and neglect or residents.
(Log 032487-18) [s. 20. (1)]

2. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents, at minimum, contain an explanation of the duty under section 24 to make mandatory reports.

As described above, the licensee's policy to promote zero tolerance of abuse and neglect was reviewed.

The policy described that all employees and affiliated personnel are to report any alleged incident of resident/patient abuse immediately to their Manager/Designate. The policy also stated that any employee or board members who is aware of or suspects improper care, incompetent treatment, unlawful conduct and the misuse or misappropriation of resident/patient property report such instances as soon as possible in accordance with reporting procedures. Further, the policy stated any person should immediately report information pertaining to abuse and/or neglect to the Director.

In this way, the licensee failed to provide an explanation of the duty under section 24 to make mandatory reports.

In addition, a written notification (WN #1) has been issued under s.24 (1) related to the licensee's failure to report alleged resident abuse immediately to the Director.
(Log 032487-18) [s. 20. (2)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of an investigation related to the alleged abuse of resident #001 were reported to the Director.

In accordance with section 105 of O. Regulation 79/10, the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident.

A critical incident report was submitted to the Director on a specified date, describing the alleged abuse of resident #001.

The lead for the licensee's investigation was identified as the CNO. In an interview with the Inspector, the CNO reported that the investigation into the alleged incident of resident abuse was initiated immediately when the licensee became aware of the allegations. The investigation concluded four days after, whereby the CNO concluded the staff member had spoken in an inappropriate manner and was disciplined accordingly.

The Director was notified of the results of the investigation 24 days after the conclusion of the investigation.
(Log 032487-18) [s. 23. (2)]

Issued on this 29th day of July, 2019

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

Original report signed by the inspector.