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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 18, 2018	2018_542511_0006	024512-17, 025757-17, 026071-17, 001707-18, 003111-18	Critical Incident System

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

Chartwell Willowgrove Long Term Care Residence
1217 Old Mohawk Road ANCASTER ON L9K 1P6

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

CYNTHIA DITOMASSO (528), YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

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

PLEASE NOTE: This inspection was completed by Robin Mackie, Lead Inspector and Yuliya Fetatova, Secondary Inspector.

This inspection was conducted on the following date(s): February 26, 27, 28, March 1, 5, 7, 8, 9, 13, 14,15, 2018.

This Inspection was completed concurrently with Follow-up Inspection # 2018_542511_0005 / 025282-17, 025285-17, 025286-17 related to Resident Abuse.

Non-compliance related to LTCHA s. 19 (1) identified during this inspection will be issued as a compliance order on Follow-up Inspection report # 2018_542511_0005/025282-17, 025285-17, 025286-17.

The following intakes were completed during this Critical Incident System Inspection.
#001707-18 related to Transferring and Positioning,
#003111-18 related to Resident Abuse,
#024512-17 related to Resident Abuse,
#025757-17 related to Transferring and Positioning
#026071-17 related to Resident Abuse,

Inquiries
#000177-18 related to Resident Abuse,
#000404-18 related to Resident Abuse,
#026374-17 related to Resident Abuse,
#026501-17 related to Resident Abuse,
#029652-17 related to Resident Abuse,

During the course of the inspection, the inspector(s) spoke with Administrator, Director(s) of Care, Registered staff inclusive of Registered Nurse(s) (RNs) and Registered Practical Nurse(s) (RPNs), Nurse Practitioner, Clinical Nurse Consultant, Personal Support Workers (PSWs), MDS-RAI Coordinator, residents and family members.

During the course of the inspection, the Inspector toured the home, observed the provision of care, reviewed clinical records, policies and procedures, the home's complaints process, investigative notes and conducted interviews.

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

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

3 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

During the course of this inspection, Administrative Monetary Penalties (AMP) were not issued.

0 AMP(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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

WN #1: 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. (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).

Findings/Faits saillants :

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

A Critical Incident report, #2921-000006-18 was received by the Ministry of Health and Long Term Care on an identified date in 2017. The report described a mandatory report for abuse by resident #007 to resident #008.

A review of resident #008's plan of care identified a safety intervention for a physical device that had been initiated on on an identified date in 2017.

Interview with registered staff #204 identified knowledge of an incident of an inappropriate behaviour demonstrated by resident #007 towards resident #008's. An intervention for a physical safety device was identified in the plan of care to ensure safety of resident #008 and was to be in place over a three month period.

Interview with PSW #208 stated the physical safety device was not in place on the identified date of the abuse. Registered staff #209 stated the physical safety device was reimplem

Interview with the DOC stated they did not have knowledge of the yellow wander guard not being in place on February 5, 2018, as per resident #008's most recent plan of care.

The licensee failed to ensure that the care set out in the plan of care, for resident #008, was provided to the resident as specified when the yellow wander guard was not in place on February 5, 2018, [s. 6. (7)]

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 ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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, without in any way restricting the generality of the duty provided for in section 19, there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with.

The Inspector reviewed the three following policies, that were provided by the home's DOC, in relation to resident abuse and neglect.

Abuse Free Communities-Prevention, Education and Analysis, LTC-CA-WQ-100-05-18, revised July 2016 described that Chartwell Willowgrove has a zero tolerance for abuse of any type and described procedures for the home's Abuse Prevention Program. This included the definition of sexual abuse as: b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation towards a resident by a person other than a licensee or staff member.

A Critical Incident report, #2921-000006-18 was received by the Ministry of Health and Long Term Care on February 5, 2018 and was amended on February 16, 2018. The report described a mandatory report for sexual abuse by resident #007 toward resident #008. Resident #007 was alleged to have entered resident #008's room around 0230 hours on February 5, 2018. The two residents were unsupervised for approximately 35 minutes when PSW #208 arrived and observed resident #007 in resident #008's bed. Resident #007 had removed their clothing, from the lower half of their body and removed the clothing, from the lower half of resident #008's body. Resident #007 was observed by PSW #208, to be between resident #007's legs.

A review of the clinical record identified that resident #008 was cognitively impaired with a cognitive performance score of six out of six. Interview with RN #204 and RN #209

stated resident #008 was unable to provide consent to any sexual touching or behaviours that would have included having their clothing removed by resident #007.

1. Abuse Allegations and Follow-up, LTC-CA-WQ-100-05-02 revised July 2016, described under the procedures that the immediate action required was for: a) the staff to separate the resident from the alleged abuser and to take the resident to a quiet and safe location and have another staff member stay with them. b) The policy further described that the resident was to be assessed immediately. Registered staff would complete a resident assessment and/or use 911 for transport to medical attention. A registered staff assessment included both physical and emotional aspects as outlined in the policy.

a) During an interview with PSW #208, they stated that after they observed resident #007 in resident #008's bed they needed to obtain help from the RN in charge. They attempted to call the RN in charge, using a walkie talkie communication device, but were unsuccessful, stating the device was not working. PSW #208 stated they had been working alone and when they were unable to contact the RN, with the walkie talkie, they left resident #007 with resident #008, still unclothed, alone in the room. The PSW stated they further left the secured home area to locate the nurse in charge. RN #209 was located in the nursing office and stated they returned with the PSW to resident #008's room, a few moments later. When the PSW and RN arrived the PSW noted that the clothing of resident #008 had been further adjusted by resident #007.

The home's policy LTC-CA-WQ-100-05-02 was not complied with when resident #007 had been left alone with resident #008, after the staff's observation of witnessed sexual abuse.

b) RN #209 stated that immediately after the event they provided a quick visual to look for any bruising prior to pulling up the bedsheets and settling resident #008 back to sleep. They stated they sat with resident #008 for approximately two or three minutes to provide comfort. A review of resident #008's clinical record had not described a physical or emotional assessment, as described in the policy, at the time of the alleged abuse. A skin assessment described as 'Investigation' was performed the following morning at 0830 hours by RN #204 .

On interview with RN #209 they stated they had not performed a head to toe assessment of resident #008 to determine if a sexual assault had occurred. The DOC stated the skin assessment completed by the day shift RN #204, approximately five hours after the alleged abuse, was not immediate as required in the home's policy.

The home's policy LTC-CA-WQ-100-05-02 was not complied with when resident #008 was not immediately assessed after the alleged sexual abuse.

3. Preserving Evidence for Alleged Sexual Abuse/Assault, LTC-CA-WQ-200-07-07 revised December 2017, described that in situations where there is an allegation of sexual abuse preservation of evidence is extremely important. Registered staff are to ensure the preservation of evidence of alleged sexual abuse in the home until the police arrive.
The procedures described that if the resident's clothing was changed that the registered staff must:
a) Put on a pair of gloves
b) Remove articles of clothing one at at time being careful not to shake or overly handle the clothing item
c) Place each articles of clothing in a separate plastic bag, label, number and tape the bag closed
d) Secure the bagged articles in a locked area until they are turned over to the police
e) Document in the resident's progress notes any conversation related to the alleged attack/description of the attacker/observations/clothing articles bagged, labeled, numbered and stored/time police were called/time family or Power of Attorney (POA) were called/resident's reaction
The policy further described the registered staff were to take pictures if there was evidence of physical injury such as bruising.
In the event the alleged assault were towards a resident who wore an incontinent product and the product had to be changed, the product was to be retained in a plastic bag that was labeled and sealed as outlined above.

Interview with RN #209 stated that immediately after the event they had assisted PSW #208 in securing the resident's incontinent product, adjusting the resident clothing and pulling up the bedsheets in an effort to resettle resident #008 back to sleep. The RN stated they returned at 0600 hours to administered eye drops to the resident and had not instructed the PSW or taken action to preserve the resident's articles of clothing or incontinent product prior to morning care. Interview with PSW #208 stated they had not been instructed not to change the resident and proceeded with providing routine morning care at 0630 hours. PSW #208 described washing the resident's perineum and surrounding area, changing their incontinent product and dressing the resident into their day clothes. The PSW stated the incontinent product was disposed of and the resident's night clothes and bed sheet were placed in the laundry as the the products were described as wet. RN #209 stated, in retrospect, they should have ensured the

preservation of the evidence of the sexual abuse to resident #008.

The home's policy LTC-CA-WQ-200-07-07 was not complied with when the home had not preserved the evidence of the alleged sexual abuse of resident #008. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that, without in any way restricting the generality of the duty provided for in section 19, there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (4) The licensee shall ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act. O. Reg. 79/10, s. 24 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the care plan was based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act.

Resident #007 was admitted to the Long-term Care Home on October 2, 2017, from a transitional bed program. Interview with the Behavioural Supports Ontario Transitional Lead (BSO TL) stated they had received a referral from the Local Health Integration Network (LHIN) placement coordinator to provide an assessment to assist with the resident's transition to long term care. The BSO TL stated they met with both the resident and resident's substitute decision maker on September 14 and 15, 2017. The

BSO TL stated they completed their assessments, written plan of care and theses were provided to the LHIN prior to admission to the home.These documents were located in the resident's clinical record. A document titled 'Responsive Behaviour Care Transitional Care Recommended Strategies' was dated September 29, 2017, and identified sexual behaviours and recommended interventions that included but were not limited to, a bed alarm be put in place with staff to respond when the alarm went off. The BSO TL identified that other interventions, identified in this same transitional plan, had been included in the home's admission plan of care, indicating the home had access to the BSO Responsive Behaviour Care Transitional Care Recommended Strategies at the time of the resident's admission.

Further admission documents included the Transitional Bed Program Plan of Care. This plan of care identified that resident #007 had mild wandering, mild sexual behaviours and included interventions to ensure a bed alarm was working to prevent nighttime wandering into clients' rooms. A Hamilton Niagara Haldimond Brant Community Care Access Centre (HNHB CCAC) Behavioural Assessment, Placement services document, dated August 10, 2017, was reviewed and indicated the resident had inappropriate sexual behaviours, wandering and a wander guard and bed alarm was utilized overnight, with good effect.

A review of resident #007's admission plan of care, as provided and verified by registered staff #203, had not included interventions to include a bed alarm or wander guard for resident #007's room, to alert staff of the resident's documented behaviour for wandering.

The licensee failed to ensure that resident #007's admission care set out in the care plan was based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act. [s. 24. (4)]

Issued on this 16th day of August, 2019

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

Original report signed by the inspector.