Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 25, 2017	2016_389601_0033	031970-16	Complaint

Licensee/Titulaire de permis

St. Joseph's at Fleming
659 Brealey Drive PETERBOROUGH ON K9K 2R8

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

ST JOSEPH'S AT FLEMING
659 Brealey Drive PETERBOROUGH ON K9K 2R8

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

KARYN WOOD (601)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 29, 30, December 1, 2, 5, 6, 7, 13, 14, 19, 20, 2016 and January 20, 2017.

The following Complaint and Critical Incident Reports (CIR) were included in this inspection:

Log #031603-16, log #031967-16, complaint log #031970-16 also included log #033424-16 and log #033793-16 related to allegations of resident abuse.

During the course of the inspection, the inspector(s) spoke with residents, family members, the Chief Executive Officer (CEO), the Director of Operation, the Director of Care (DOC), Unit Managers (UM), Manager of Quality and Education, the Physician, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), a Security Guard and a Peterborough Police Inspector.

The Inspector also observed interactions between staff to residents, reviewed resident health care records, the licensee's critical incident reports and investigation documentation, documentation provided by the complainant and the licensee policies related to complaints and abuse.

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

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 resident #001, #002 and #003 were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Under O. Reg. 79/10, s. 2 (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, emotional abuse" means, subject to subsection (1)(a) 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; "verbal abuse" means, subject to subsection (a) 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; "physical abuse" means, subject to subsection (2)(a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Log #031603-16 related to resident #002:

Inspector #601 reviewed the Critical Incident Report (CIR) and identified that on an identified date and time, PSW #117 witnessed PSW #110 speaking to resident #002 in a demeaning manner.

During an interview, PSW #117 indicated to Inspector #601 and #641 that resident #002's facial expression changed when PSW #110 spoke to the resident in a demeaning manner.

Log #031967-16 related to resident #003:

Inspector #601 reviewed the CIR and identified that on the same identified date and time as resident #002, PSW #117 witnessed PSW #110 mocking resident #003 by repeating what the resident was saying.

During an interview, PSW #117 indicated to Inspector #601 and #641 that PSW #110 mocked resident #003's identified statement by repeating resident #003's comment. According to PSW #117, resident #003's facial expression changed and the resident did not respond at this time.

During an interview, PSW #117 indicated to Inspector #601 and #641 that the nurse working the day shift was busy and reported the incident's regarding resident #002 and #003 to RN #116 at change of shift, approximately one hour and forty-five minutes following the incidents.

During an interview, RN #116 indicated to Inspector #601 and #641 that on the identified date approximately one hour and forty-five minutes following the incident, PSW #117 reported the allegations of staff to resident verbal abuse involving resident #002 and #003 at change of shift. During the same interview, RN #116 indicated that resident #002 and #003 had already gone to bed and PSW #110 had left for the day. RN #116 indicated that resident #002 and #003's SDM were not immediately notified of the witnessed incident due to further information was required to complete the investigation. During the same interview, RN #116 indicated that the Director should have been notified upon becoming aware of the incidents involving both residents and PSW #110. During the same interview, RN #116 also indicated that the reporting timelines to the Director were not complied with.

The two CIR's involving resident #002 and #003 were submitted to the Director the following day, one day after the incident.

During an interview, Unit Manager (UM) #102 indicated to Inspector #601 and #641 that PSW #110 was suspended for allegations of verbal and emotional abuse involving resident #002 and #003.

Inspector #601 reviewed PSW #110's notice of discipline letter and identified that PSW #110's behaviour on the identified date was considered verbal and emotional abuse. The letter directed PSW #110 to complete a learning plan, review Resident's Rights, Abuse and Neglect – Zero Tolerance policy number 14-18 and the Employees Code of Conduct. The letter requested that PSW #110 review, sign and return signed copies to UM #102 on an identified date.

A review of the licensee's Abuse and Neglect – Zero Tolerance policy number 14-18 dated June 2016 was completed by Inspector #601. The policy indicated that strategies for prevention of abuse directs staff to:

1. Allow family members and resident's time to express or communicate when they become upset. Admission is a most challenging experience and therefore it's important to allow residents and family members the opportunity to express themselves if they are upset, without taking it personally.
2. Communicate effectively and do not escalate the situation by becoming upset.
3. Report any concerns to the charge nurse and inquire as to follow-up.
4. Monitor your stress level and take care of yourself. Avoid caffeine, alcohol or drugs. Obtain proper rest and eat properly. Try to have periods of relaxation. Debrief if and

when needed.
5. If in an area unfamiliar, check care plans and ask for direction prior to attending to the resident.
6. Review strategies for responsive behaviour. Refer to BSO team when needed.
7. Communication can be the biggest cause of stress. Report to team members any incidents while working, of responsive behaviours with dementia residents.
8. Indicators of stress can include anxiety/irritability/anger. Sleep disturbances as well as poor concentration, could lead to excessive stress like headache, dizziness, sweating and poor concentration.
9. Communicate to team members if having any symptoms and take time to debrief. If a member of the team reports these symptoms to you, provide them opportunity to debrief.
10. Plan before you start your day. Organized processes will relieve stress burden.
11. Take care of yourself and seek confidential employee assistance counseling, if required.

During an interview, UM #102 indicated to Inspector #601 and #641 that PSW #110 returned to work on an identified date, prior to completing the learning plan which included reviewing Resident's Rights, the licensee's Abuse and Neglect - Zero Tolerance policy number 14-18 and the Employee Code of Conduct. On the same day PSW #110 returned to work and a third allegation of abuse occurred that was physical in nature involving PSW #110 while providing resident #001's care.

Log #031970-16:

Inspector #601 reviewed the CIR and the licensee's internal investigation. Inspector #601 identified that on the same day PSW #110 returned to work, PSW #110 and #105 were providing resident #001's continence care prior to getting the resident out of bed. The CIR indicated that resident #001 was physically resisting care and made verbal statements of discomfort. The CIR also indicated that PSW #110 was holding resident #001's identified body part down with both hands on the bed and an identified injury was observed by PSW #105 on resident #001's identified body part following continence care. The CIR also indicated that PSW #110 was no longer an employee of the home following the third incident.

Inspector #601 reviewed resident #001's clinical health records and identified that resident #001 required two staff for continence care related to cognitive impairment and inability to toilet self.

Inspector #601 reviewed resident #001's care plan and identified that resident #001's current care plan indicated that resident #001 may exhibit self-protective behaviours during care. Resident #001's care plan developed strategies included to allow for flexibility during care and if resident refuses care to leave the resident and return in five to ten minutes.

During an interview, PSW #105 indicated to Inspector #601 and #641 that on the identified date and time PSW #110 and #105 were providing resident #001's continence care while in bed. PSW #105 indicated to Inspector #601 that resident #001 was physically resisting care and asked PSW #110 to gently hold resident #001's identified body part. PSW #105 indicated hearing resident #001 make verbal statements of discomfort while providing continence care and observed PSW #110 holding resident #001's identified body part down on the bed. During the same interview, PSW #105 indicated to Inspector #601 and #641 that they did not leave and re-approach resident #001. PSW #105 indicated that both PSW's continued resident #001's continence care and PSW #105 indicated just wanting to get the care finished. PSW #105 indicated noticing the identified injury on resident #001's identified body part following care and reported the incident to RPN #107.

During an interview, Unit Manager (UM) #102 indicated to Inspector #601 and #641 that PSW #110 and PSW #105 were providing resident #001's continence care on the same day PSW #110 returned to work. During the same interview, UM #102 indicated that PSW #105 was upset and reported PSW #110 to RPN #107 after completing resident #001's continence care and after noticing the resident's identified injury. UM #102 indicated an immediate investigation was initiated and that PSW #105 reported that during continence care resident #001 was making an identified verbal statement of discomfort, while PSW #110 was holding the resident's identified body part due to the resident physically resisting care.

A review of the licensee's Abuse and Neglect – Zero Tolerance policy number 14-18 dated June 2016 was completed by Inspector #601. The policy indicated that the responsibility of employees who witness or suspect alleged abuse or neglect directs staff to:

-Intervene to ensure resident/staff safety and well-being, if abuse is occurring. Remove resident from imminent danger. Provide emotional reassurance. Provide 1:1 time for reassurance and comfort to the resident.

On the identified date and time, resident #001 was physically resisting care and made verbal statements of discomfort, PSW #110 and #105 did not implement the developed strategies to leave the resident and return in five to ten minutes in response to the demonstrated responsive behaviour. Resident #001 sustained an injury to an identified body part during continence care. PSW #105 had observed PSW #110 holding resident #001's identified body part down during care and the resident was verbally indicating discomfort. PSW #105 did not intervene or remove resident #001 from imminent risk to ensure the resident's safety and well-being.

Inspector #601 reviewed PSW #110's termination of employment letter and identified that PSW #110 had physically restrained resident #001 causing a wound located on the resident's identified body part.

In summary, on an identified date and time, PSW #110 was observed speaking to resident #002 and #003 by PSW #117 in a demeaning manner, however PSW #117 failed to immediately report the incidents to the nurse and RN #116 failed to immediately report the allegations of abuse to the residents SDM's and the Director. UM #102 determined that PSW #110 had been verbally and emotionally abusive towards resident #002 and #003. UM #102 was aware that PSW #110 had not completed the identified learning plan and permitted PSW #110 to return to work on an identified date. There was no documentation that PSW #110 had been provided strategies as identified in the licensee's Abuse and Neglect – Zero Tolerance policy number 14-18 dated June 2016 for prevention of abuse following the incidents that occurred on the identified date.

During an interview, PSW #105 indicated hearing resident #001 making verbal statements of discomfort while providing continence care and observed PSW #110 holding resident #001's identified body on the same day that PSW #110 returned to work. During continence care resident #001 sustained an injury and PSW #105 did not intervene to ensure the safety and well-being of resident #001.

The licensee also failed to comply with:

1. LTCHA, s. 20 (1) The licensee has failed to ensure that the Abuse and Neglect – Zero Tolerance policy number 14-18 dated June 2016 was complied with for resident #001. (refer to WN #2)

2. LTCHA, s. 24 (1) The licensee has failed to ensure that a person who had 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 risk of harm to resident #002 and #003 by not immediately reporting the suspicion and the information upon which it was based to the Director. (refer to WN #3)

3. O. Reg. 79/10, s. 53. (4)(b) The licensee has failed to ensure that the strategies developed for resident #001 were implemented related to self-protective actions in response to the demonstrated responsive behaviours. (refer to WN #4)

4. O. Reg 79/10, s. 97. (1)(a) The licensee has failed to ensure that resident #002 and #003 Substitute Decision Maker (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 caused distress to the resident that could potentially be detrimental to the residents health or well-being. (refer to WN #5)

The application of factors to be taken into account under section 299 (1) of O Regulation 79/10, requires a Compliance Order because of the severity and scope of the issues, in respect of the actual harm caused to the residents involved, as well as the high level of risk posed to all residents of the home when the Licensee fails to take all the necessary steps to ensure that residents in the home are safe from staff verbal and physical abuse they were aware of.

Despite there being no history of non-compliance with s.19 (1) of the LTCHA by the Licensee in the last three years, the scope and severity outweigh the factor of the compliance history; thus the issuance of Order #001. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written report documenting the response the licensee made to the complainant under subsection 101 (1) after receiving a written complaint with respect to a matter that the licensee reported to the Director under section 24 of the Act.

Log #031970-16:

Inspector #601 reviewed a complaint letter that was addressed to the Chief Executive Officer (CEO) and signed by resident #001's Substitute Decision Maker (SDM) on an identified date. The complaint letter was noted to have been received by the CEO two days later and was related to a Physician completing an examination of resident #001 in a public area and allegations of emotional abuse.

During an interview by telephone, the CEO indicated to Inspector #601 that he had forwarded the complaint letter to the Director on the identified date that the letter was received. The CEO also indicated that an email had been sent to resident #001's SDM on an identified date and time with an explanation and the reason resident #001's complaint regarding the Physician was unfounded. During the same interview, the CEO indicated that the licensee's written report documenting the response made to the complainant was not submitted to the Director.

The licensee failed to submit a written report to the Director documenting the response the licensee made to the complainant regarding the complaint letter received by the CEO on the identified date from resident #001's SDM.

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 written report documenting the response the licensee made to the complainant under subsection 101 (1) after receiving a written complaint with respect to a matter that the licensee reported to the Director under section 24 of the Act, to be implemented voluntarily.

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Abuse and Neglect – Zero Tolerance policy number 14-18 dated June 2016 was complied with for resident #001.

A review of the licensee's Abuse and Neglect – Zero Tolerance policy number 14-18 dated June 2016 was completed by Inspector #601. The policy indicated that the responsibility of employees who witness or suspect alleged abuse or neglect directs staff to:

-Intervene to ensure resident/staff safety and well-being, if abuse is occurring. Remove resident from imminent danger. Provide emotional reassurance. Provide 1:1 time for reassurance and comfort to the resident.

Under O.Reg. 79/10, s. 2 (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, subject to subsection (2) (a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Log #031970-16:

Inspector #601 reviewed the CIR and the licensee's internal investigation. Inspector #601 identified that on an identified date and time, PSW #110 and #105 were providing resident #001's continence care prior to getting the resident out of bed. The CIR indicated that resident #001 was physically resisting care and made verbal statements of discomfort. The CIR also indicated that PSW #110 was holding resident #001's identified body part down with both hands on the bed and an identified injury was observed by PSW #105 on resident #001's identified body part following continence care.

During an interview, PSW #105 indicated to Inspector #601 and #641 that on the identified date and time PSW #110 and #105 were providing resident #001's continence care while in bed. PSW #105 indicated to Inspector #601 that resident #001 was resisting care in a physical manner and asked PSW #110 to gently hold resident #001's identified body part. PSW #105 indicated hearing resident #001 making statements of verbal discomfort while providing continence care and observed PSW #110 holding resident #001's identified body part down. During the same interview, PSW #105 indicated to Inspector #601 and #641 that they did not leave and re-approach resident #001. PSW #105 indicated that both PSW's continued resident #001's continence care and PSW #105 indicated just wanting to get the care finished. PSW #105 indicated noticing the injury on resident #001's identified body part following care and reported the incident to RPN #107.

During an interview, Unit Manager (UM) #102 indicated to Inspector #601 and #641 that PSW #110 and PSW #105 were providing resident #001's continence care on the identified date and time. During the same interview, UM #102 indicated that PSW #105 was upset and reported PSW #110 to RPN #107 after completing resident #001's continence care and after noticing resident #001's identified injury. UM #102 indicated an immediate investigation was initiated and that PSW #105 reported that during continence care resident #001 was making verbal statements of discomfort while PSW #110 was holding the resident's identified part due to the resident physically resisting care.

On the identified date and time, resident #001 sustained an identified injury during continence care. Resident #001 was physically resisting care and made verbal statements of discomfort, PSW #105 had observed PSW #110 holding resident #001's identified body part down during care and did not intervene or remove the resident from imminent danger to ensure the resident's safety and well-being. [s. 20. (1)]

WN #4: 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 :

The licensee has failed to ensure that a person who had 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 risk of harm to resident #002 and #003 by not immediately reporting the suspicion and the information upon which it was based to the Director.

Log #031603-16 involving resident #002:

Inspector #601 reviewed the CIR. The CIR indicated that on an identified date and time, PSW #117 witnessed PSW #110 speaking to resident #002 in a demeaning manner. The CIR was submitted to the Director by Unit Managers (UM) #101 and #102 on the following day.

During an interview, RN #116 indicated to Inspector #601 and #641 that the Director should have been notified upon becoming aware of the incident involving resident #002 and PSW #110. RN #116 also indicated that reporting timelines to the Director were not complied with.

The CIR was submitted to the Director the following day, one day after the incident.

Log #031967-16 involving resident #003:

Inspector #601 reviewed the CIR. The CIR indicated that on an identified date and time, PSW #117 witnessed PSW #110 mocking resident #003 by repeating the statement made by resident #003. The CIR was submitted to the Director by Unit Managers (UM) #101 and #102 on the following day.

During an interview, RN #116 indicated to Inspector #601 and #641 that the Director should have been notified upon becoming aware of the incident involving resident #003 and PSW #110. RN #116 also indicated that the reporting timelines to the Director were not complied with.

The CIR was submitted to the Director the following day, one day after the incident. [s. 24. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the strategies developed for resident #001 were implemented related to self-protective actions in response to the resident's demonstrated responsive behaviour of resisting care.

Log #031970-16:

Inspector #601 reviewed resident #001's clinical health records and identified that resident #001 required two staff for continence care related to cognitive impairment and inability to toilet self.

Inspector #601 reviewed the CIR and the licensee's internal investigation. Inspector #601 identified that on the identified date and time, PSW #110 and #105 were providing resident #001's continence care prior to getting the resident out of bed. The CIR indicated that resident #001 was physically resisting care and making verbal statements of discomfort. The CIR also indicated that PSW #110 was holding resident #001's identified body part down on the bed with both hands and an identified injury was observed by PSW #105 on resident #001's identified body part following continence care.

During an interview, PSW #105 indicated to Inspector #601 and #641 that on the identified date and time PSW #110 and #105 were providing resident #001's continence

care while in bed. PSW #105 indicated to Inspector #601 that resident #001 was physically resisting care and asked PSW #110 to gently hold resident #001's identified body part. PSW #105 indicated hearing resident #001 make verbal statements of discomfort while washing the resident's bottom and observed PSW #110 holding resident #001's identified body part down on the bed. During the same interview, PSW #105 indicated to Inspector #601 and #641 that they did not leave and re-approach resident #001. PSW #105 indicated that both PSW's continued providing resident #001's continence care and PSW #105 indicated just wanting to get the care finished. PSW #105 indicated noticing resident #001's identified injury following care and reported the incident to RPN #107.

Inspector #601 reviewed resident #001's care plan and identified that resident #001's current care plan indicated that resident #001 may exhibit self-protective behaviours during care. Resident #001's care plan developed strategies included to allow for flexibility during care and if resident refuses care to leave the resident and return in five to ten minutes.

On the identified date and time, resident #001 was physically resisting care and was making verbal statements of discomfort. PSW #110 and #105 did not implement the developed strategies to leave the resident and return in five to ten minutes in response to the demonstrated responsive behaviour. [s. 53. (4) (b)]

WN #6: 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 resident #002 and #003 Substitute Decision Maker (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 caused distress to the resident that could potentially be detrimental to the residents health or well-being.

Log #031603-16 involving resident #002:

Inspector #601 reviewed the CIR. The CIR indicated that on an identified date and time, PSW #117 witnessed PSW #110 speaking to resident #002 in a demeaning manner.

During an interview, PSW #117 indicated to Inspector #601 and #641 that resident #002 looked upset and the resident's facial expression changed when PSW #110 spoke to the resident in a demeaning manner. During the same interview, PSW #117 indicated that the nurse working the day shift was busy and reported the incident to RN #116 at change of shift.

During an interview, RN #116 indicated to Inspector #601 and #641 that on the identified date approximately one hour and forty-five minutes following the incident, PSW #117 reported the allegations of staff to resident verbal abuse at change of shift. During the same interview, RN #116 indicated that resident #002 had already gone to bed and that PSW #110 had left for the day. RN #116 indicated that resident #002 SDM was not immediately notified of the witnessed incident because further information was required

to complete the investigation.

2. Log #031967-16 involving resident #003:

Inspector #601 reviewed the CIR. The CIR indicated that on an identified date and time, PSW #117 witnessed PSW #110 mocking resident #003 by repeating what the resident was saying.

During an interview, PSW #117 indicated to Inspector #601 and #641 that PSW #110 mocked resident #003 by repeating resident #003's comment. According to PSW #117, resident #003's facial expression changed and the resident didn't respond at this time. During the same interview, PSW #117 indicated that the nurse working the day shift was busy and reported the incident to RN #116 at change of shift.

During an interview, RN #116 indicated to Inspector #601 and #641 that on the identified date approximately one hour and forty-five minutes following the incident, PSW #117 reported the allegations of staff to resident verbal abuse at change of shift. During the same interview, RN #116 indicated that resident #003 had already gone to bed and that PSW #110 had left for the day. RN #116 indicated that resident #003's SDM was not immediately notified of the witnessed incident because further information was required to complete the investigation. [s. 97. (1) (a)]

Issued on this 31st day of January, 2017

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

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

Ministére de la Santé et des Soins de longue durée

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KARYN WOOD (601)
Inspection No. / No de l'inspection :	2016_389601_0033
Log No. / Registre no:	031970-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 25, 2017
Licensee / Titulaire de permis :	St. Joseph's at Fleming 659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8
LTC Home / Foyer de SLD :	ST JOSEPH'S AT FLEMING 659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Patrick Gillespie

To St. Joseph's at Fleming, you are hereby required to comply with the following order (s) by the date(s) set out below:

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. 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 shall ensure that the licensee's Abuse and Neglect policy number 14-8 is complied with and a monitoring process is developed and implemented to protect residents in incidents of alleged, suspected or witnessed abuse.

The monitoring process shall include, but is not limited to:

a) a process whereby residents exhibiting responsive behaviours are identified, triggers to the behaviours are identified, and for each behaviour identified, strategies are implemented to assist staff in managing the responsive behaviours;

b) a process whereby the Director of Care and/or delegate is reviewing all communication from the front line staff at least daily to determine the presence of suspected, alleged or witnessed incidents of resident abuse;

c) a process whereby an effective information-sharing protocol amongst all members of the multidisciplinary health care team, the residents, their families is established to ensure supervisory and management staff always have current, reliable and comprehensive information about suspected, alleged or witnessed incidents of resident abuse;

d) a process whereby, when there are reasonable grounds to suspect that abuse has occurred, the licensee and/or delegate conducts immediately a thorough investigation, ensuring that all legislative requirements have been fulfilled, especially as it relates to the assessment of the residents involved and the implementation of interventions to meet their needs for support and protection;

e) a process to assess the knowledge and skills of all staff in relation to the implementation of the licensee's Abuse and Neglect policy number 14-8, in order to effectively address deficiencies thru targeted, focused and individualized interventions; and

f) a formal linkage to the home's quality improvement program, to ensure that all aspects of the development and implementation of the required monitoring process are documented, reviewed and analyzed on an ongoing basis to determine the need for further corrective actions.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that resident #001, #002 and #003 were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Under O. Reg. 79/10, s. 2 (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, emotional abuse" means, subject to subsection (1) (a) 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; "verbal abuse" means, subject to subsection (a) 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; "physical abuse" means, subject to subsection (2)(a) the use of physical force by anyone other than a resident that causes physical injury or pain.

Log #031603-16 related to resident #002:

Inspector #601 reviewed the Critical Incident Report (CIR) and identified that on an identified date and time, PSW #117 witnessed PSW #110 speaking to resident #002 in a demeaning manner.

During an interview, PSW #117 indicated to Inspector #601 and #641 that resident #002's facial expression changed when PSW #110 spoke to the resident in a demeaning manner.

Log #031967-16 related to resident #003:

Inspector #601 reviewed the CIR and identified that on the same identified date and time as resident #002, PSW #117 witnessed PSW #110 mocking resident #003 by repeating what the resident was saying.

During an interview, PSW #117 indicated to Inspector #601 and #641 that PSW #110 mocked resident #003's identified statement by repeating resident #003's comment. According to PSW #117, resident #003's facial expression changed and the resident did not respond at this time.

During an interview, PSW #117 indicated to Inspector #601 and #641 that the

nurse working the day shift was busy and reported the incident's regarding resident #002 and #003 to RN #116 at change of shift, approximately one hour and forty-five minutes following the incidents.

During an interview, RN #116 indicated to Inspector #601 and #641 that on the identified date approximately one hour and forty-five minutes following the incident, PSW #117 reported the allegations of staff to resident verbal abuse involving resident #002 and #003 at change of shift. During the same interview, RN #116 indicated that resident #002 and #003 had already gone to bed and PSW #110 had left for the day. RN #116 indicated that resident #002 and #003's SDM were not immediately notified of the witnessed incident due to further information was required to complete the investigation. During the same interview, RN #116 indicated that the Director should have been notified upon becoming aware of the incidents involving both residents and PSW #110. During the same interview, RN #116 also indicated that the reporting timelines to the Director were not complied with.

The two CIR's involving resident #002 and #003 were submitted to the Director the following day, one day after the incident.

During an interview, Unit Manager (UM) #102 indicated to Inspector #601 and #641 that PSW #110 was suspended for allegations of verbal and emotional abuse involving resident #002 and #003.

Inspector #601 reviewed PSW #110's notice of discipline letter and identified that PSW #110's behaviour on the identified date was considered verbal and emotional abuse. The letter directed PSW #110 to complete a learning plan, review Resident's Rights, Abuse and Neglect – Zero Tolerance policy number 14 -18 and the Employees Code of Conduct. The letter requested that PSW #110 review, sign and return signed copies to UM #102 on an identified date.

A review of the licensee's Abuse and Neglect – Zero Tolerance policy number 14 -18 dated June 2016 was completed by Inspector #601. The policy indicated that strategies for prevention of abuse directs staff to:

1. Allow family members and resident's time to express or communicate when they become upset. Admission is a most challenging experience and therefore it's important to allow residents and family members the opportunity to express themselves if they are upset, without taking it personally.

2. Communicate effectively and do not escalate the situation by becoming upset.
3. Report any concerns to the charge nurse and inquire as to follow-up.
4. Monitor your stress level and take care of yourself. Avoid caffeine, alcohol or drugs. Obtain proper rest and eat properly. Try to have periods of relaxation. Debrief if and when needed.
5. If in an area unfamiliar, check care plans and ask for direction prior to attending to the resident.
6. Review strategies for responsive behaviour. Refer to BSO team when needed.
7. Communication can be the biggest cause of stress. Report to team members any incidents while working, of responsive behaviours with dementia residents.
8. Indicators of stress can include anxiety/irritability/anger. Sleep disturbances as well as poor concentration, could lead to excessive stress like headache, dizziness, sweating and poor concentration.
9. Communicate to team members if having any symptoms and take time to debrief. If a member of the team reports these symptoms to you, provide them opportunity to debrief.
10. Plan before you start your day. Organized processes will relieve stress burden.
11. Take care of yourself and seek confidential employee assistance counseling, if required.

During an interview, UM #102 indicated to Inspector #601 and #641 that PSW #110 returned to work on an identified date, prior to completing the learning plan which included reviewing Resident's Rights, the licensee's Abuse and Neglect - Zero Tolerance policy number 14-18 and the Employee Code of Conduct. On the same day PSW #110 returned to work and a third allegation of abuse occurred that was physical in nature involving PSW #110 while providing resident #001's care.

Log #031970-16:

Inspector #601 reviewed the CIR and the licensee's internal investigation. Inspector #601 identified that on the same day PSW #110 returned to work, PSW #110 and #105 were providing resident #001's continence care prior to getting the resident out of bed. The CIR indicated that resident #001 was physically resisting care and made verbal statements of discomfort. The CIR also indicated that PSW #110 was holding resident #001's identified body part down with both hands on the bed and an identified injury was observed by PSW

#105 on resident #001's identified body part following continence care. The CIR also indicated that PSW #110 was no longer an employee of the home following the third incident.

Inspector #601 reviewed resident #001's clinical health records and identified that resident #001 required two staff for continence care related to cognitive impairment and inability to toilet self.

Inspector #601 reviewed resident #001's care plan and identified that resident #001's current care plan indicated that resident #001 may exhibit self-protective behaviours during care. Resident #001's care plan developed strategies included to allow for flexibility during care and if resident refuses care to leave the resident and return in five to ten minutes.

During an interview, PSW #105 indicated to Inspector #601 and #641 that on the identified date and time PSW #110 and #105 were providing resident #001's continence care while in bed. PSW #105 indicated to Inspector #601 that resident #001 was physically resisting care and asked PSW #110 to gently hold resident #001's identified body part. PSW #105 indicated hearing resident #001 make verbal statements of discomfort while providing continence care and observed PSW #110 holding resident #001's identified body part down on the bed. During the same interview, PSW #105 indicated to Inspector #601 and #641 that they did not leave and re-approach resident #001. PSW #105 indicated that both PSW's continued resident #001's continence care and PSW #105 indicated just wanting to get the care finished. PSW #105 indicated noticing the identified injury on resident #001's identified body part following care and reported the incident to RPN #107.

During an interview, Unit Manager (UM) #102 indicated to Inspector #601 and #641 that PSW #110 and PSW #105 were providing resident #001's continence care on the same day PSW #110 returned to work. During the same interview, UM #102 indicated that PSW #105 was upset and reported PSW #110 to RPN #107 after completing resident #001's continence care and after noticing the resident's identified injury. UM #102 indicated an immediate investigation was initiated and that PSW #105 reported that during continence care resident #001 was making an identified verbal statement of discomfort, while PSW #110 was holding the resident's identified body part due to the resident physically resisting care.

A review of the licensee's Abuse and Neglect – Zero Tolerance policy number 14 -18 dated June 2016 was completed by Inspector #601. The policy indicated that the responsibility of employees who witness or suspect alleged abuse or neglect directs staff to:

-Intervene to ensure resident/staff safety and well-being, if abuse is occurring. Remove resident from imminent danger. Provide emotional reassurance. Provide 1:1 time for reassurance and comfort to the resident.

On the identified date and time, resident #001 was physically resisting care and made verbal statements of discomfort, PSW #110 and #105 did not implement the developed strategies to leave the resident and return in five to ten minutes in response to the demonstrated responsive behaviour. Resident #001 sustained an injury to an identified body part during continence care. PSW #105 had observed PSW #110 holding resident #001's identified body part down during care and the resident was verbally indicating discomfort. PSW #105 did not intervene or remove resident #001 from imminent risk to ensure the resident's safety and well-being.

Inspector #601 reviewed PSW #110's termination of employment letter and identified that PSW #110 had physically restrained resident #001 causing a wound located on the resident's identified body part.

In summary, on an identified date and time, PSW #110 was observed speaking to resident #002 and #003 by PSW #117 in a demeaning manner, however PSW #117 failed to immediately report the incidents to the nurse and RN #116 failed to immediately report the allegations of abuse to the residents SDM's and the Director. UM #102 determined that PSW #110 had been verbally and emotionally abusive towards resident #002 and #003. UM #102 was aware that PSW #110 had not completed the identified learning plan and permitted PSW #110 to return to work on an identified date. There was no documentation that PSW #110 had been provided strategies as identified in the licensee's Abuse and Neglect – Zero Tolerance policy number 14-18 dated June 2016 for prevention of abuse following the incidents that occurred on the identified date.

During an interview, PSW #105 indicated hearing resident #001 making verbal statements of discomfort while providing continence care and observed PSW #110 holding resident #001's identified body on the same day that PSW #110 returned to work. During continence care resident #001 sustained an injury and

PSW #105 did not intervene to ensure the safety and well-being of resident #001.

The licensee also failed to comply with:

1. LTCHA, s. 20 (1) The licensee has failed to ensure that the Abuse and Neglect – Zero Tolerance policy number 14-18 dated June 2016 was complied with for resident #001. (refer to WN #2)

2. LTCHA, s. 24 (1) The licensee has failed to ensure that a person who had 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 risk of harm to resident #002 and #003 by not immediately reporting the suspicion and the information upon which it was based to the Director. (refer to WN #3)

3. O. Reg. 79/10, s. 53. (4)(b) The licensee has failed to ensure that the strategies developed for resident #001 were implemented related to self-protective actions in response to the demonstrated responsive behaviours. (refer to WN #4)

4. O. Reg 79/10, s. 97. (1)(a) The licensee has failed to ensure that resident #002 and #003 Substitute Decision Maker (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 caused distress to the resident that could potentially be detrimental to the residents health or well-being. (refer to WN #5)

The application of factors to be taken into account under section 299 (1) of O Regulation 79/10, requires a Compliance Order because of the severity and scope of the issues, in respect of the actual harm caused to the residents involved, as well as the high level of risk posed to all residents of the home when the Licensee fails to take all the necessary steps to ensure that residents in the home are safe from staff verbal and physical abuse they were aware of.

Despite there being no history of non-compliance with s.19 (1) of the LTCHA by the Licensee in the last three years, the scope and severity outweigh the factor of the compliance history; thus the issuance of Order #001. [s. 19. (1)] (601)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 13, 2017

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 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 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:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 25th day of January, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Karyn Wood

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