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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 11, 2016	2016_288549_0019	019828-16, 020213-16	Critical Incident System

Licensee/Titulaire de permis

ROYAL OTTAWA HEALTH CARE GROUP
1141 Carling Avenue OTTAWA ON K1Z 7K4

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

ROYAL OTTAWA PLACE
1145 CARLING AVENUE OTTAWA ON K1Z 7K4

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

RENA BOWEN (549)

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): July 4, 5, 6, 7, 2016

Log # 019828-16 is related to staff to resident alleged abuse.
Log # 020213-16 is related to resident to resident alleged abuse

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), a Housekeeper, Registered Practical Nurses (RPN), Registered Nurses (RN), Human Resources Specialist, Manager of Security, Parking and Safety, Manager of Resident and Family Services and Recreation Therapy, Manager of Patient Care Services and the Administrator/Director of Care.

During the course of the inspection the inspector reviewed resident health care files, Ontario Review Board documentation, Intermittent/Constant Observation Record, a staff personnel file, the home's Zero Tolerance of Resident Abuse and Neglect policy, staff education records, Royal Ottawa Healthcare Group Incident Report and unit and lobby video recording report.

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

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

- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, specifically 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 the resident.

The home submitted a Critical Incident Report on a specific day in July 2016 indicating the alleged sexual abuse of resident #001.

O. Reg. 79/10 defines sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member ("mauvais traiement d'order sexual").

Resident #001 was admitted to the home on a specific day in February 2016 with multiple diagnoses.

The Minimum Data Set (MDS) assessment dated a specific day in June 2016 indicated that the resident has no short term or long term memory problems and a Cognitive Performance Scale (CPS) of one. Resident #001 makes all decisions for care and finances.

During an interview on July 6, 2016 resident #001 indicated to Inspector #549 that resident #002 had touched him/her inappropriately while they were in the elevator together. Resident #001 indicated that resident #002 stopped touching the resident when asked to stop. Resident #001 indicated he/she cannot recall the specific date however, does recall that there was no one else in the elevator at the time.

Resident #002's MDS assessment dated a specific day in June 2016 indicates that the resident had no short term or long term memory problems and a CPS of one.

Inspector #549 reviewed resident #001's progress notes dated a specific day in June 2016. The progress notes indicated that resident #001 reported to RN #105 that resident #002 touched the resident inappropriately in the elevator at an identified earlier date. The progress notes indicated that RN #105 informed resident #001 that the "concern has to be brought to higher management".

During an interview on July 6, 2016 RN #105 confirmed with Inspector #549 that she was the charge nurse for the building. During the interview RN #105 indicated to Inspector #549 that she recalls resident #001 disclosing to her on a specific day in June 2016, that resident #002 touched him/ her inappropriately while in the elevator at an identified earlier date. RN #105 indicated to Inspector #549 that she had sent an internal correspondence on a specific day in June 2016 at a specified time to the Administrator/Director of Care (ADM/DOC) outlining the incident. RN #105 indicated that she is uncertain if she called the On Call Manager. The home's process it to notify the On Call Manager after regular hours. RN #105 was unable to provide documentation indicating that the On Call Manager was notified.

During an interview on July 6, 2016 the Manager of Patient Care and Services (MPCS) indicated that the home's process is for the Charge RN to notify the On Call Manager for any unusual occurrences. The MPCS indicated that the home does not have a record of the On Call Manager being notified of the alleged sexual abuse of resident #001 on a specific day in June 2016.

The ADM/DOC indicated to Inspector #549 that the home did not notify the Director immediately of resident #001's disclosure of the alleged sexual abuse by resident #002.

In summary the licensee failed to ensure that the Director was notified immediately of the alleged sexual abuse of resident #001. The licensee became aware of the alleged

sexual abuse on a specific day in June 2016 and notified the Director on a specific day in July 2016 which was eight days after the home became aware of the alleged sexual abuse of resident #001. [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 every person who has reasonable ground to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, specifically 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 be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 222. Exemptions, training

Specifically failed to comply with the following:

s. 222. (2) The licensee shall ensure that the persons described in clauses (1) (a) to (c) are provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 76 (2) of the Act before providing their services. O. Reg. 79/10, s. 222 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the persons described in clauses (1) (a) to (c) of O. Reg. 222(1) are provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 76 (2) of the Act before providing their services. O. Reg. 79/10, s. 222 (2).

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

In accordance with LTCHA, 2007 S.O. 2007, c.8, s.2 (1) "staff, in relation to a long-term care home, means persons who work at the home, (a) as employees of the licensee, (b) pursuant to a contract or agreement with the licensee, or (c) pursuant to a contract or agreement between the licensee and an employment agency or other third party; (personnel")

During an interview on July 4, 2016 the ADM/DOC indicated to Inspector #549 that the Royal Ottawa Place (ROP) has an agreement with the Royal Ottawa Hospital (ROH) to provide staff who are classified as orderlies to provide constant observation of residents. The orderly staff do not provide direct resident care. The ADM/DOC indicated that the orderlies meet the requirements of LTCHA, 2007 S.O. 2007, c.8, s. 2(1) for exception of training.

The licensee notified the Director of an alleged sexual abuse of resident #001 on a specific day in July 2016. At the time of the alleged sexual abuse resident #001 was on constant observation.

Inspector #549 reviewed resident #001's progress notes for the specified period. The progress note indicated that on a specific day in June 2016 resident #001 was upset and became aggressive with staff. Two code whites were called on a specific day in June 2016 resulting in the resident requiring constant observation commencing on a specified day in July 2016.

The home contacted the ROH scheduler who was able to provide an orderly to provide constant observation of resident #001. Orderly #112 provided constant observation for a specific time period then was replaced by orderly #110 for a specific time period on a specified day July 2016. The constant observation was discontinued on a specified day in July 2016 by the on call physician.

During an interview on July 5, 2016 the ADM/DOC and the Manager of Patient Care Services indicated that the orderlies were not provided with information items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 76 (2) of the Act before providing services. The information items are as listed:
1. Resident's Bill of Rights
3. The long term care home's policy to promote zero tolerance of abuse and neglect of residents
4. The duty under section 24 to make mandatory reports
5. The protections afforded by section 28

7. Fire prevention and safety
8. Emergency and evacuation procedures
9. Infection prevention and control.

In summary the licensee failed to provide the orderlies with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8, and 9 of subsection 76(2) of the Act before providing their service. [s. 222. (2)]

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 orderlies who are employees of the Royal Ottawa Hospital who are requested to provide constant observation for residents at the Royal Ottawa Place are provided the following information before providing their services: Resident's Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports, the protections afforded by section 28, fire prevention and safety, emergency and evacuation procedures and infection prevention and control, to be implemented voluntarily.

Issued on this 12th day of July, 2016

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

Original report signed by the inspector.