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 29, 2016	2016_200148_0023	008338-16, 005500-16, 015701-16, 015771-16	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

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): July 25, 26 and 27, 2016

This inspection included five critical incident reports , two related to a fall and associated improper care, two related to alleged abuse and one related to an unexpected death.

During the course of the inspection, the inspector(s) spoke with the home's Administrator/Director of Care, Manager of Family Services, Registered Nurses, Registered Practical Nurses, Personal Care Aids, family and residents.

The Inspector also reviewed resident health care records, policy and program documents related to the falls management and prevention program and the home's policy to promote zero tolerance of abuse and neglect of residents.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
3 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	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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that appropriate action is taken in response to every alleged, suspected or witnessed incident of abuse of a resident by anyone.

A Critical Incident Report (CIR), was received by the Director alleging that on or around a specified date, a staff member verbally abused residents #003 and #004.

In accordance with O.Regulation 79/10, s.2(1), 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.

During the inspection it was discovered that on a specified date, initial information regarding alleged verbal abuse was received by the home's Manager of Family Services, who was in the position of Administrator at the time of the incident. The email indicated that PCA #101 made comments such as "why don't you shut up and don't tell me my job". The information further indicated that PCA #101 was ruff with residents when providing dressing care and transfers.

The home's investigation began immediately after receiving information of the alleged abuse. The Administrator (Manager of Family Services), along with other management and union representatives, interviewed PCA #101 and residents #003 and #004. As confirmed with the Manager of Family Services, no other interviews were conducted as

part of the home's investigation. During the home's investigation interviews with residents #003 and #004 indicated that PCA #101 made comments such as “shut your mouth and don’t tell me what to do”. An indication of roughness was not made by either resident at the interviews held during the home's investigation, however, as reported to the Inspector no direct questions were asked about this allegation.

The following are three facts derived from the home’s investigation:
-In a meeting with PCA #101, resident #003 identified PCA #101 as not being the correct staff member who made the comments reported;
-Resident #004 identified PCA #102 and PCA #103 as being potential witnesses to inappropriate comments made by PCA #101;
-In the interview with PCA #101, she indicated that residents often mistake him/her for PCA #104 .

The Administrator (Manager of Family Services) requested permission from the licensee’s human resource department to interview PCA #102 and PCA #103, but was denied due to related union structure and lack of reason to question the staff members.

The licensee failed to take appropriate action in that staff identified by initial interviews were not questioned to assist in the information gathering process to ensure that all efforts were made to establish the validity of the complaint of alleged abuse and potentially identify the appropriate staff member involved. In addition, the initial complaint also contained information related to dressing and transfer care. As confirmed, efforts were not made to establish the validity of the complaint of alleged abuse and potentially identify the appropriate staff member involved for the dates in question. [s. 23. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that appropriate action including interviews with relevant staff members, is taken in response to every alleged, suspected or witnessed incident of abuse of a resident by anyone, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

In accordance with O.Regulation 79/10, s.30(1)1 and s.49, the licensee shall ensure the development and implementation of a falls prevention and management program to reduce the incidence of falls and the risk of injury. As a required program the licensee must have a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk.

A Critical Incident Report, was received by the Director and indicated that on a specified date, resident #001 had a fall during the provision of care and sustained injury requiring surgical repair.

During a review of the resident's health care record it was noted that the home utilized an electronic Falls Risk Assessment form. Resident #001, who was admitted September 2004, had a Fall Risk Assessment completed in 2004, 2006, 2007, 2008, 2009 and 2010. A Falls Risk Assessment was next completed on a date soon after the fall described above.

The home's falls prevention and management program includes a pathway that directs staff to complete a Falls Risk Assessment Tool (F.R.A.T.) within 24 hours of admission, when there is a change in health status and quarterly on services where the length of stay is greater than 90 days.

As it relates to resident #001, a fall risk assessment had not been completed since 2010 until the fall of February 2016. [s. 8. (1) (a),s. 8. (1) (b)]

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. (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 failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents, at a minimum, shall contain an explanation of the duty under section 24 to make mandatory reports.

The home’s policy to promote zero tolerance of abuse and neglect of residents is titled Zero Tolerance of Resident Abuse and Neglect, #110, last reviewed May 26, 2016. Within the policy statement reads the following: The ROHCG-ROP-LTC requires a person who has reasonable grounds to suspect that a resident has suffered or may suffer abuse and/or neglect to immediately report the suspicion and the information on which it is based on the resident, if the resident is not already aware. Staff will inform the resident of their obligation to report the incident to their manager. Any person who suspects abuse or neglect can report this to the MOHLTC.

The policy includes the elements of the duty to make mandatory reports under s.24 of the Act, however the explanation does not include that a person who has reasonable grounds to suspect that abuse or neglect of a resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director. In addition, the explanation of s.24 does not includes paragraph 1, 3, 4 or 5, as it relates to mandatory reporting of improper or incompetent care, unlawful contact and misuse or misappropriation of resident’s money or funding provided to the licensee. [s. 20. (2)]

Issued on this 2nd day of August, 2016

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

Original report signed by the inspector.