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
Feb 9, 2017	2017_615638_0004	010104-16, 000466-17	Complaint

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH CENTRE OF SUDBURY
1140 South Bay Road SUDBURY ON P3E 0B6

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

ST.GABRIEL'S VILLA OF SUDBURY
4690 Municipal Road 15 Chelmsford ON P0M 1L0

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

RYAN GOODMURPHY (638)

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): January 23 - 27, 2017.

Two intakes were completed in this complaint inspection;
- One log was related to alleged resident to resident abuse; and
- One log was related to alleged staff to resident abuse.

A Follow-Up inspection was conducted concurrently with this inspection. For details, please refer to inspection report #2017_615638_0003.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping staff, residents and their family members.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant personnel files, licensee policies, procedures, programs relevant training and health care records.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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. 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 written policy that promoted zero tolerance

of abuse and neglect of residents was complied with.

A complaint with a related critical incident report (CIS) was submitted to the Director. The complaint intake alleged that an incident of staff to resident abuse had occurred in April 2016. The CIS intake alleged that PSW #109 physically and verbally abused resident #002. The CIS report indicated that resident #002 had sustained multiple new areas of altered skin integrity upon being assessed.

Physical abuse is defined within the Ontario Regulation 79/10 (O.Reg 79/10) as the use of physical force by anyone other than a resident that caused physical injury or pain.

Inspector #638 reviewed the complaint letter submitted by PSW #110 to the DOC related to the incident of alleged abuse which occurred to resident #002. The letter indicated that resident #002 demonstrated responsive behaviours during their care. The letter indicated that PSW #109 had responded with physical and verbal actions. It was also indicated that resident #002 had yelled out in pain in response to PSW #109.

In a review of resident #002's progress notes, Inspector #638 identified that PSW #110 documented that the resident became physically and verbally responsive while staff were providing care to the resident.

Inspector #638 reviewed the head to toe assessment completed on resident #002. The assessment indicated that resident #002 had sustained multiple new areas of altered skin integrity after the incident of alleged abuse.

In a review of resident #002's care plan that was in effect at the time of the incident, Inspector #638 noted that when the resident displayed responsive behaviours, the staff were to implement a specific set of interventions, none of which included physical or verbal interventions.

Inspector #638 reviewed the internal investigation notes which included an interview conducted between the DOC and PSW #109. The notes indicated PSW #109 had used verbal and physical actions towards resident #002 and the resident responded by calling out in pain.

Inspector #638 reviewed a letter served to PSW #109 by the DOC. The letter confirmed that PSW #109 had admitted to using physical action towards resident #002. The letter indicated that the alleged abuse was substantiated in the sense that PSW #109 had

physically restrained resident #002 and made inappropriate comments contrary to their training.

The home's policy titled "Zero Tolerance for Abuse and Neglect" last revised September 14, 2015, indicated that residents would be free from abuse by staff, volunteers, visitors and other residents.

In an interview with Inspector #638, PSW #110 stated that they had witnessed the incident of staff to resident abuse which had occurred during their evening shift. PSW #110 stated that PSW #109 physically restrained them and verbally abused the resident. PSW #110 stated that they felt uncomfortable with the interactions between resident #002 and PSW #109 and felt as though resident #002 had been physically and verbally abused.

During an interview with PSW #109, they stated that they were performing care on resident #002, during the evening shift. Resident #002 became physically responsive and PSW #109 stated that they physically restrained resident #002 and had told the resident to stop their responsive behaviours. PSW #109 stated that during the incident resident #002 had cried out saying that PSW #109 was hurting them. PSW #109 then stated that they should have removed themselves from the situation in order to allow the behavior to de-escalate prior to re-attempting care.

Inspector #638 conducted an interview with the DOC who stated that PSW #109 was not following the home's policy titled "Zero Tolerance for Abuse and Neglect" due to their actions while caring for resident #002. [s. 20. (1)]

2. A complaint with a related CIS report was submitted to the Director, which alleged staff to resident physical abuse. Please refer to WN #1, finding "1." for details.

In a review of resident #002's progress notes, Inspector #638 identified that PSW #110 charted that the resident became physically and verbally responsive while staff were providing care to the resident.

Inspector #638 reviewed a complaint letter submitted by PSW #110 one day later, to the DOC related to an incident of what was believed to be abuse toward resident #002, which occurred during their period of care giving. Upon review of the letter, it was determined that the incident of alleged abuse was reported one day later and not immediately after the incident had occurred.

The home's policy titled "Zero Tolerance of Abuse and Neglect" last revised September 14, 2015, indicated that any employee or volunteer who witnessed, or became aware of, or suspected resident abuse would have reported it immediately to the DOC, Administrator or delegate.

In an interview with Inspector #638, PSW #110 stated that they had witnessed an incident of what they believed was physical and verbal abuse between PSW #109 and resident #002, however, did not report the incident until the next day. PSW #110 then stated that all incidents of witnessed, suspected or alleged abuse were required to be reported immediately in order to ensure resident safety and this incident should have been reported immediately.

Inspector #638 conducted an interview with the DOC who indicated that all incidents of suspected, alleged or witnessed abuse were required to be reported immediately to the designate in order to initiate an immediate investigation and protect the residents from harm. [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 to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: 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 the abuse of a resident by anyone, immediately reported the suspicion and the information upon which it was based to the Director.

A complaint with a related CIS report was submitted as an "Incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status" to the Director. The CIS report was reported on a specific day in November 2016, related to the incident between resident #007 and resident #004 which had occurred the day before it was reported. Inspector #638 reviewed the CIS report which determined that resident #007 had demonstrated physically responsive behaviours to resident #004. Please refer to WN #3 for details.

Physical abuse is defined within the O.Reg 79/10 as the use of physical force by a resident that causes physical injury to another resident.

Inspector #638 reviewed the progress notes of resident #007 and #004, which indicated that the resident #007 had pushed resident #004 in an aggressive manner. This caused resident #004 to fall sustaining an injury.

In an interview with Inspector #638, RPN #106 stated that any incidents related to abuse would be reported to the DOC or designate. The DOC or designate would use the

information related to the incident and determine if it was required to be reported to the Director.

The home's policy titled "Staff Reporting and Whistle Blowing Protection" last revised September 14, 2016, stated that staff must immediately report all alleged, suspected or witnessed incidents of abuse of a resident by anyone.

In an interview with Inspector #638, the DOC stated that they had reported the incident and that they had interpreted the incident as a fall because resident #007 pushed resident #004's wheelchair and did not specifically push resident #004. The Inspector reviewed the "Licensee Reporting of Physical Abuse" decision tree with the DOC which indicated that if a resident had applied physical force to another resident which resulted in harm, it was required to have been immediately reported to the Director.

Upon review of the progress notes, decision tree and incident notes with the DOC, they stated that due to the specific actions of resident #007, the incident should have been reported immediately as abuse. [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 the person who has reasonable grounds to suspect that the abuse of a resident by anyone, immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #3: 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 behavioural triggers were identified for the resident demonstrating responsive behaviours.

A complaint was submitted to the Director related to alleged resident to resident abuse between resident #007 and resident #004 in November 2016. The complaint alleged that resident #007 had physically attacked resident #004. The incident caused resident #004 to fall from their wheelchair and sustain an injury.

A CIS report related to this complaint was submitted to the Director in November 2016. The CIS report indicated that resident #007 had demonstrated physically responsive behaviours towards resident #004 in their wheelchair while they were in a specific home area, resident #004 fell from their wheelchair and sustained an injury. The CIS report further indicated that Inspector #106 spoke to the DOC in January 2017, to inquire about resident #007's care plan interventions.The notes indicated that resident #007's care plan did not identify specific information related to behaviours within specific home areas and that they would amend the care plan after their interview due to the trend of behaviours.

Inspector #638 conducted a review of the progress notes for resident #007 which indicated that resident #007 told RPN #106 that they pushed resident #004 due to a specific behaviour.

The Inspector further reviewed the progress notes for resident #007 over a six month period, Inspector #638 identified six occasions in which resident #007 had demonstrated physically responsive behaviours involving other residents while in a specific home area.

After the incident in November 2016, resident #007's behaviours increased and the Inspector identified an additional three incidents in December 2016, where they had displayed physically responsive behaviours towards other residents in a specific home area.

In an interview with Inspector #638, PSW #107, RPN #106 and RN #105 all stated that resident #007 had a history of physically responsive behaviours in that specific home area and often became agitated by a particular trigger. PSW #107 stated that resident #007 had a significant history of physically responsive behaviours in that specific home area. RN #105 stated that resident #007 had demonstrated these types of behaviours since admission in and would have expected this to have been included in their plan of care as an identified trigger.

Inspector #638 conducted a review of resident #007’s care plan in effect at the time of the incident, which gave no indication that the resident was at times physically responsive towards other residents in the specific home area.

The home’s policy titled “Responsive Behaviours” last revised June 6, 2016, indicated that the plan of care for every resident who had demonstrated responsive behaviours would at minimum address the behavioural triggers of the resident. The Inspector noted that resident #007's care plan was amended one day after the DOC's discussion with Inspector #106, to identify these behaviours after their interview with Inspector #106.

In an interview with Inspector #638, the DOC stated that prior to their telephone discussion with Inspector #106 in January 2017, resident #007’s care plan did not identify that one of resident #007’s physically responsive behavioral triggers. The DOC stated that staff would not necessarily be aware of resident needs if it was not included in their plan of care and would be unable to respond to behaviours effectively. [s. 53. (4) (a)]

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 behavioural triggers are identified for residents demonstrating responsive behaviours, where possible, to be implemented voluntarily.

Issued on this 28th day of February, 2017

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

Original report signed by the inspector.