Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 29, 2020	2020_822613_0012	014154-20	Critical Incident System

Licensee/Titulaire de permis

Algoma Manor Nursing Home
145 Dawson Street THESSALON ON P0R 1L0

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

Algoma Manor Nursing Home
145 Dawson Street THESSALON ON P0R 1L0

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

LISA MOORE (613)

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 21 - 23, 2020.

The following intake was inspected during this Inspection:

One Critical Incident report that was submitted to the Director regarding improper/incompetent treatment of a resident.

A concurrent Complaint Inspection #2020_822613_0013 was also conducted during this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director/Administrator (ED/ADM), Office Manager (OM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

The Inspector also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed personnel files, health care records, internal investigation files and policies, procedures and programs.

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.
- **1 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	Légende 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 their written policy to promote zero tolerance of abuse and neglect of residents was complied with related to an incident of abuse involving resident #001.

The Long-Term Care Homes Act, 2007 O. Reg 79/10, defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being and includes and inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Inspector #613 reviewed a Critical Incident (CI) report that was submitted to the Director, that identified witnessed staff to resident abuse involving resident #001 during care rounds. The CI report identified that PSW #104 reported to RPN #109 that PSW #100 had showed them how to tie the resident's article of clothing in a knot and pull it over the resident's head to keep resident #001's arms confined while they provided care. The CI report identified that PSW #104 reported that PSW#100 informed them that PSW #106 had taught them how to tie the clothing and pull it over the resident's head.

A review of the licensee's policy titled, "Prevention of Abuse and Neglect of a Resident" (VII-G-10,.00) last updated April 2019, identified that all residents have the right to dignity, respect, and freedom from abuse and neglect. All team members were required to immediately report any suspected or known incident of abuse or neglect to the provincial health authorities and the Executive Director or designate in charge of the care community. If any team member witnessed an incident, or had any knowledge of an incident, that constituted resident abuse or neglect, all team members were responsible to immediately inform the Executive Director and/or Nurse in charge.

A review of the home's internal investigation file revealed that there were several instances where staff had not followed the licensee's policy titled, "Prevention of Abuse and Neglect of a Resident" and included the following documentation:

-that the incident had occurred on a specific date and time.

-PSW #104 did not immediately report the abuse on the shift that it had occurred. The PSW reported the witness abuse to RPN #109 on their following scheduled shift.

-RPN #109 immediately reported the abuse to RN #111, who was the shift Charge Nurse.

-RN #111 did not immediately report the abuse to the Director or the Executive Director/Administrator (ED/ADM) when they had knowledge regarding the incident. RN #111 directed RPN #109 to email the ED/ADM, and later reported the incident to the next oncoming shift's Charge Nurse RN#110, who then notified the Director and ED/AMD.

-During the home's investigation, PSW #106 denied showing PSW #100 how to tie the resident's clothing in front and pull it over the resident's head during care.

-During the home's investigation, PSW #100 confirmed they had provided care to resident #001 and had "folded their article of clothing and tied it, but did not recall placing the article of clothing over the resident's head and they recalled tucking their article of clothing."

During interviews with PSW #102, PSW #105, RPN #107 and RPN #108, they all stated that they were to report suspected, alleged and witnessed abuse and neglect immediately to the Charge Nurse (RN).

During interviews with RN #110 and RN #112, they both stated that they were to notify the Director immediately of suspected, alleged and witnessed abuse and neglect.

During interview with the ED/ADM, they confirmed that PSW #104, PSW #100 and RN #111 had not followed the licensee's, "Prevention of Abuse and Neglect of a Resident" policy. The ED/ADM further stated that PSW #104 should have reported the witness abuse immediately to the Charge Nurse (RN) on the shift that the incident had occurred, and that RN #111 should have immediately reported the critical incident to the Director when they had been informed. The ED/ADM confirmed that PSW #100 had not provided the appropriate care to resident #001 and had put them at risk of 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 their written policy to promote zero tolerance of abuse and neglect of residents is complied with by all staff, to be implemented voluntarily.

Issued on this 29th day of July, 2020

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

Original report signed by the inspector.