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
Mar 6, 2020	2020_772691_0008	002159-20, 002706-20, 003078-20	Complaint

Licensee/Titulaire de permis

The Regional Municipality of Halton
1151 Bronte Road OAKVILLE ON L6M 3L1

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

Allendale
185 Ontario Street South MILTON ON L9T 2M4

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

JENNIFER NICHOLLS (691), SYLVIE BYRNES (627)

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): February 24-28, 2020.

**During the course of this Complaint Inspection, the following logs were inspected:
-One Log, related to a complaint submitted to the Director related to an allegation of staff to resident abuse; and an incident of resident to resident abuse;**

Two Critical Incident System intake(s) related to the same concerns were completed during this Complaint inspection.

Critical Incident System Inspection #2020_772691_0006 and Follow up Inspection #2020_772691_0007 were conducted concurrently with this Complaint Inspection.

Off site Inspection activities occurred from March 2-3, 2020.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nurse Managers, Social Worker, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

The Inspector (s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, and resident to resident interactions, reviewed relevant health care records, internal investigation notes, as well as licensee policies, procedures and programs.

**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.

- **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	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. 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 abuse of a resident by anyone that resulted in harm or risk of harm had occurred or may occur, immediately reported the suspicion and the information upon which it was based on to the Director.

A complaint was submitted to the Director on an identified date regarding an incident that occurred on an identified date, involving resident #003. The complainant indicated that PSW #118 allegedly caused an injury to resident #003 during a specified intervention.The complainant identified that resident #003 sustained a identified injury; and, stated that they were upset as they were not notified of this incident until the following day. The complainant further identified, that they also were not notified until an identified date, regarding another incident that occurred on an identified date, when resident #004 displayed responsive behaviors towards resident #003, resulting in a resident #003 having an identified response.

A review of the licensee's policy titled, "Prevention, Reporting & Eliminating of Abuse & Neglect", #01-05-03, last revised November 2018, directed any person who had reasonable grounds to suspect abuse or neglect of a resident were to immediately report the suspicion to the Director. The licensee's policy further directed an employee who was advised of/or had first hand knowledge of abuse/neglect or suspected abuse/neglect to immediately inform their manager/supervisor.

Inspector #691 interviewed Registered Practical Nurse (RPN) #112, and RPN #114, who both verified that their understanding of mandatory reporting requirements, were that every form of abuse should be immediately reported to their supervisor/manager who would report to the Ministry.

a)A Critical Incident (CI) report was submitted to the Director on an identified date, for an incident that took place on an identified date prior.The CI indicated that RPN #112 noted resident #003 had an identified injury. The CI further indicated that resident #003 indicated to RPN #112 that on the identified date, an identified staff member caused an identified injury while assisting the resident with an intervention for a specified activity of daily living (ADL).

Inspector #691 reviewed the health care records of resident #003, which identified a progress note on an identified date, in which RPN #117, had documented resident #003 had a specified injury. Resident #003 had indicated to RPN #117 the injury occurred during a specified intervention, and they could not remember which staff it was; no further documentation indicated RPN #117 reported this allegation of suspected abuse to their manager/supervisor or the Director.

Inspector #691 reviewed the home’s internal investigation notes regarding this incident. The Inspector identified in an interview note, on an identified date that Personal Support Worker (PSW) #106 reported immediately at the start of their shift to RPN #117, that resident #003 had an identified injury. The PSW further identified that resident #003 stated "staff on an identified shift did it when they got the resident up.”

Inspector #691 conducted an interview with PSW #106 who indicated that they immediately reported to RPN #117 on the identified date, resident #003's specified injury.

Inspector #691 interviewed Nurse Manager (NM) #115 who indicated that all staff were trained on mandatory reporting of incidents of alleged or suspected abuse. The NM verified RPN #117 had documented the incident in the progress notes, but the incident was not reported to the on-call manager. NM #115 indicated to the Inspector that the manager on call should have been notified in order for the incident to be immediately reported to the Director, and it was not.

Inspector #691 interviewed the Director of Care (DOC), who indicated that all staff were trained on mandatory reporting of any alleged or suspected abuse. The DOC also

identified that all registered staff were to contact the manager on call for alleged or suspected abuse to be reported to the Director immediately, and it was not.

b)A CI was submitted to the Director on an identified date, for resident #004 exhibiting responsive behaviors towards resident #003 that occurred on an identified date, which was four days prior.

Inspector #691 reviewed the health care records of resident #003, which identified a progress note dated on an identified date, in which RPN #117 had documented resident #004 was exhibiting responsive behaviors towards resident #003, including resident #004 exhibiting an identified response towards resident #003. Further review, identified that resident #003's Substitute Decision Maker (SDM) reported on an identified date, that they were concerned for the safety of resident #003 and they wanted information regarding the incident with resident #004. A further review of resident #003's progress notes could not identify any progress notes indicating RPN #117 reported this allegation of suspected abuse to their manager/supervisor or the Director.

Inspector #691 interviewed resident #003 which they described the incident and they displayed a identified response towards resident #004.

Inspector reviewed the internal investigation notes which identified an email on February 14, 2020, from RPN #117 advising NM #115 about the incident between resident #003 and resident #004. The email from RPN #117 to NM #115 stated that resident #003 was upset after this incident and they did not feel safe around resident #004.

Inspector #691 interviewed NM #115 who indicated that all staff were trained on mandatory reporting of incidents of alleged or suspected abuse, including emotional. The NM identified that RPN #117 had documented an incident in the progress notes on identified date, which resident #004 exhibiting responsive behaviors towards #003. The NM further identified that RPN #117 sent an email to NM #115 regarding the incident, the NM #115 identified that they did not receive the email until returning to work on an identified date. The NM further confirmed the incident was not reported to the on-call manager. NM #115 indicated to the Inspector that the manager on call should have been notified in order for the incident to be immediately reported to the Director, and it was not.

Inspector #691 interviewed the DOC, who indicated that all staff were trained on mandatory reporting of any alleged or suspected abuse, including emotional. The DOC

also identified that all registered staff were to contact the manager on call for all alleged or suspected abuse this to be reported to the Director immediately and identified that this incident was not. [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 abuse of a resident by anyone, is immediately reported to the Director, to be implemented voluntarily.

WN #2: 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 the resident's 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: resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident' s health or well-being.

A complaint was submitted to the Director on an identified date, regarding an incident

that occurred on identified date, involving resident #003. The complainant indicated that PSW #118 allegedly caused an injury to resident #003 during a specified intervention. The complainant identified that they were not notified of this incident until the following day.The complaint further identified, they also were not notified until an identified date, regarding another incident that occurred on an identified date, when resident #004 displayed responsive behaviors towards resident #003, resulting in an identified response to resident #003.

A review of the licensee's policy titled, "Prevention, Reporting & Eliminating of Abuse & Neglect", #01-05-03, last revised November 2018.The licensee's policy directed an employee who was advised of/or had first hand knowledge of abuse/neglect or suspected abuse/neglect were to immediately inform their manager/supervisor. The Administrator, Senior Nursing Manager or designate would immediately notify the SDM or others identified in the resident's health record of the incident resulted in physical injury or pain or caused distress detrimental to the resident's well-being. For any other type of alleged, suspected or witnessed abuse or neglect, the SDM was to be notified of the incident within 12 hours.

a)Inspector #691 reviewed resident #003's progress notes from an identified date, which identified a progress note from RPN #117 indicating resident had a specified injury, and resident advised RPN #117 the incident had occurred during a specified intervention and they could not identify the staff member.

Inspector #691 continued to review progress notes from an identified date, and could not identify any documentation or communication with SDM regarding resident #003's allegation of potential abuse.

b) Inspector #691 reviewed resident #003's progress notes from the evening of an identified date, which identified a progress note from RPN #117 indicating an incident in which resident #004 displayed identified responsive behaviors towards resident #003.

Inspector #691 continued to review progress notes from an identified date, and could not identify any documentation or communication with the SDM regarding incident.

Upon further review of progress notes, Inspector #691 identified a progress note on the evening of an identified date, by RPN #114, indicating that the SDM of resident #003 was inquiring about the incident with resident #004 and stated that they were not notified.

Inspector #691 interviewed NM #115, who indicated that all staff were responsible for notifying the SDM of any alleged or suspected abuse immediately. They further identified that the home did not notify the SDM immediately regarding incidents with resident #003.

Inspector #691 interviewed the DOC, who indicated that the SDM was not notified immediately by the home regarding the allegation of suspected abuse or the incident with resident #004 and should have been. [s. 97. (1) (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 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, to be implemented voluntarily.

Issued on this 9th day of March, 2020

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

Original report signed by the inspector.