**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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 9, 2018 | 2018_556168_0007 | 016498-18 | Complaint |

**Licensee/Titulaire de permis**

The Regional Municipality of Niagara
1815 Sir Isaac Brock Way THOROLD ON L2V 4T7

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

The Meadows of Dorchester
6623 Kalar Road NIAGARA FALLS ON L2H 2T3

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

LISA VINK (168)

## 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): September 12, 13, and 20, 2018.**

**This inspection was conducted related to log number 016498-18 related to prevention of abuse and neglect.**

**This inspection was conducted concurrently with Critical Incident Inspection, log number 019209-17.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), recreation staff, the Resident and Family Support Worker and residents.**

**During the course of the inspection, the inspector observed the provision of care and services and reviewed relevant records including training, clinical health, policies and procedures and investigative notes.**

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

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

- **5 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A.  Resident #012 was identified to demonstrate an activity at times which inadvertently resulted in an undesired outcome. This activity was know to staff as verbalized during an interview with PSW #100, during the course of the inspection and recorded in Critical Incident Report (CIS) M515-000002-18.
A review of the Incident Report identified that on an identified date in January 2018, the resident displayed this action.
As a result of the incident and the known activity staff attempted to implement additional interventions, in an effort to prevent the outcome for the resident.  This intervention was trialed on or before an identified date in January 2018, according to hand written notes of the DOC on the identified date in January 2018, and a statement of the DOC during the inspection.
A review of the plan of care did not include a focus statement specific to the activity or the intervention until an identified date in February 2018, as confirmed following a review of the plan of care by RPN #106.

B.  Following an incident on an identified date in January 2018, staff implemented a change in routine for resident #012.
Interviews with PSW #100, RPN #103 and the DOC during the inspection, identified that the resident was now consistently seated in a specific area, when awake, for a specific reason.
Observations of the resident, during the course of the inspection, verified the location of the resident as communicated by staff.
A review of the plan of care did not include that the resident was to be consistently seated in the area, a change in their previous routine, for the desired reason, as confirmed during a telephone interview with the DOC.

C. Resident #011 demonstrated a responsive behaviour, towards resident #012, on an identified date in January 2018, according to a review of progress notes and Critical Incident Report M515-000002-18.
Interviews with RPN #103 and RN #107, during the inspection, and a review of the clinical record, suggested that this was not a known behaviour for the resident at the time of the occurrence.

A review of the plan of care in place, on a specified date in September 2018, identified that a focus statement for this behaviour and interventions were not included into the plan until an identified date in July 2018, as confirmed by RPN #107 and by the DOC during interviews conducted during the inspection.

The resident was not reassessed and the plan of care reviewed and revised when the resident's care needs changed. [s. 6. (10) (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 the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

**Specifically failed to comply with the following:**

**s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the resident was protected from abuse by anyone.

LTCHA, 2007, 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.

A. A review of Critical Incident Report M515-000002-18 identified an incident of resident abuse.
The Incident Report identified that on a specific date in January 2018, resident #011 and

resident #012 were involved in an incident which met the definition of sexual abuse. The two residents were immediately separated by staff and resident #011 was redirected. Resident #012 was provided care, assessed and "did not appear to be upset with the incident".
The incident as recorded above was confirmed, by interview, during the inspection, with PSW #100 who was a witness.

Resident #012 was identified in their Minimum Data Set (MDS) assessment dated in November 2017, with a specific level of functioning under cognitive patterns.
Interview with the DOC, during the inspection, verified that resident #012 was not able to consent to being touched.

At the time of the incident resident #011 did not have a history of non-consensual touching, which was verified by RN #107 and the DOC during interviews conducted during the inspection.
Their MDS assessments dated in November 2017 and January 2018, identified a specific level of functioning under cognitive patterns.

Resident #012 was not protected from abuse by resident #011.

B. A review of Critical Incident Report M515-000009-18 identified an incident of resident abuse.
The Incident Report identified that on a specified date in July 2018, resident #011 and resident #010 were involved in an incident which met the definition of sexual abuse. Resident #010 responded to the incident with a movement to push away the co-resident . The two residents were immediately separated by staff. Resident #010 was provided reassurance and support, as identified during interviews conducted during the inspection, with PSW #102, who witnessed the incident and RPN #117, who worked on the identified shift.

Resident #010 was identified in their MDS assessments dated in May 2018 and August 2018, with a specific level of functioning under cognitive patterns.
Interview with the DOC, during the inspection, verified that resident #010 was not able to consent to being touched.

At the time of the incident resident #011 had a history of non-consensual touching.
Their MDS assessments dated in June 2018 and September 2018, identified under cognitive patterns, a specific level of functioning.

Resident #010 was not protected from abuse by resident #011. [s. 19. (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 resident is protected from abuse by anyone, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

**s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A. Resident #012 and #011 were involved in an incident on a specified date in January 2018, according to a review of the progress notes and Critical Incident Report M515-000002-18.
Following a review of the records for both residents it was identified that the incident and the immediate actions taken were recorded in the residents' progress notes; however, the record did not include notes related to follow up monitoring or the status of the residents following the incident.
Interview with RPN #013, who worked when the incident occurred, verified that they did monitor the residents following the incident and following a review of the progress notes, for resident #012, suggested that the lack of documentation was an oversight.
Telephone interview with the DOC, during the inspection, following a review of the clinical record of resident #011, confirmed the the lack of documentation.
Interviews with RN #107 and the DOC confirmed the expectation that staff would monitor residents following this type of incident and document their assessment findings.

The licensee failed to ensure that any actions taken with respect to a resident under a program were documented. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.***

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**WN #4: 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 failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

The licensee had a policy and procedure "Abuse and Neglect - Zero Tolerance", number RR00-001, with a revised date in July 2014, and a reviewed date of in April 2018, which identified that "a report of an alleged or witnessed incident of abuse or neglect must be immediately reported to the Director of Resident Care, Administrator, or designate immediately".

According to Critical Incident Report M515-000002-18, on an identified date in January 2018, at a specified time, there was an incident of resident abuse. Interview, conducted during the inspection, with PSW #100, who witnessed the abuse, identified that they reported the abuse immediately, to RPN #103, after they ensured the safety of the resident.
RPN #103 identified, during an interview, that they notified RN #104, over the telephone, of the incident, within a few minutes of becoming aware of the situation.
Interview with RN #104, during the inspection, verified that they were informed of the incident by the RPN, but that they had no recall of notifying management of the situation immediately as required. They suggested that the incident was likely communicated to management during a review of the shift report on a subsequent date.
Interview with the DOC, during the course of the inspection, verified that they were not informed of the incident on the identified date in January 2018, as required.

The policy was not complied with by RN #104. [s. 20. (1)]

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**WN #5: 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 failed to ensure that a person who had reasonable grounds to suspect that the following had occurred or did occur, immediately reported the suspicion and the information upon which it was based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

According to Critical Incident Report M515-000009-18, an incident of 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 was identified on a specific date in July 2018, at a specific time, and the incident was not reported to the Director until the following day, at a specific time.

Interview with the DOC, during the inspection, confirmed that the incident was reported to the Associate DOC, by RN #116, on the specified date in July 2018, during the identified shift, as required by the procedure of the licensee; however, it was not reported to the Director until the following day. The incident was reported via the Critical Incident System and not immediately as required.

A person, who had reasonable grounds to suspect that abuse of a resident by anyone, failed to immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

**Issued on this 12th day of October, 2018**

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

**Original report signed by the inspector.**