Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

**Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**
**Division de la responsabilisation et de la performance du système de santé**
**Direction de l'amélioration de la performance et de la conformité**

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**Public Copy/Copie du public**

| Date(s) of inspection/Date(s) de l'inspection | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| Mar 20, 21, 22, 23, 26, 27, Apr 2, 4, 2012 | 2012_053122_0007 | Mandatory Reporting |

**Licensee/Titulaire de permis**

THE CORPORATION OF THE CITY OF THUNDER BAY CITY CLERKS OFFICE
500 DONALD ST, E., THUNDER BAY, ON P7C 5K4

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

GRANDVIEW LODGE
200 LILLIE STREET, THUNDER BAY, ON, P7C-5Y2

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

ROSE-MARIE FARWELL (122)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Mandatory Reporting inspection.**

**During the course of the inspection, the inspector(s) spoke with the Director of Nursing (DON), the Assistant Director of Nursing (ADON), Registered Staff, PSWs, Resident Councillor, the Resident's Power of Attorney, the Elder Abuse Officer**

**During the course of the inspection, the inspector(s) reviewed the resident's health care record, documentation related to the home's internal investigation, various policies and procedures.**

**The following Inspection Protocols were used during this inspection:**

**Personal Support Services**

**Prevention of Abuse, Neglect and Retaliation**

**Findings of Non-Compliance were found during this inspection.**

## NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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| Legend | Legendé |
|---|---|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | 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.) | 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. |
| The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. | 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 subsections:**

**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.**
**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.**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident.**
**4. Misuse or misappropriation of a resident's money.**
**5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).**

**Findings/Faits saillants :**

The Inspector reviewed the home's corporate Resident Incident Report on March 20, 2012. The Resident Incident report identified that on February 11, 2012, at 15:30 hours, the evening shift RPN observed bruising to the resident's genitalia while bathing the resident.

The RPN was interviewed by the Inspector on March 21, 2012 and reported that bruising to the resident's genitalia was observed while bathing the resident during the evening shift of February 11, 2012. The RPN reported that the bath was conducted between 15:15 - 15: 45 hrs, the RN was notified of the RPN's observations between 17:00 - 18:00 hrs and the RN assessed the resident's bruised genitalia between 19:00 - 20:00 hrs.

The Assistant Director of Nursing was interviewed by the Inspector on March 22, 2012 and reported receiving a phone call from the RN on the afternoon of February 12, 2012 at approximately 1600 hrs. The ADON was made aware of bruising to the resident's genitalia at that time.

The Inspector reviewed the home's case notes and the Critical Incident and noted that the Director was not notified of bruising to the resident's genitalia until February 13, 2012.

The licensee failed to ensure that a person who has reasonable grounds to suspect that (1) improper or incompetent care of a resident that resulted in harm or a risk of harm to the resident or (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 had occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director. [ LTCHA 2007, S.O., c.8, 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 with LTCHA 2007, S.O., c. 8, s.24 (1) to ensure that a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to a resident or abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director., to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance**
**Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,**
**(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;**
**(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;**
**(c) identifies measures and strategies to prevent abuse and neglect;**
**(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and**
**(e) identifies the training and retraining requirements for all staff, including,**
**(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and**
**(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.**

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**Findings/Faits saillants :**

1. The Inspector reviewed the licensee's Zero Tolerance of Abuse Policy on March 23, 2012 and noted the policy does not identify the training and retraining requirements for all staff including training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care. The policy also does not identify the training and retraining requirements for all staff regarding situations that may lead to abuse and neglect and how to avoid such situations.

The licensee failed to ensure that the home's zero tolerance of abuse policy identified the training and retraining requirements for all staff including training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care and failed to identify the training and retraining requirements for all staff regarding situations that may lead to abuse and neglect and how to avoid such situations. [LTCHA 2007, O. Reg. 79/10, s. 96 (e)]

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2. The Inspector reviewed the licensee's Zero Tolerance of Abuse Policy on March 23, 2012 and noted that the policy does not clearly identify specific interventions or provide clear directions to staff identifying what supports are to be provided to residents who have been abused/neglected or allegedly abused/neglected.

The licensee failed to ensure that the zero tolerance of abuse policy clearly identified specific interventions regarding supports which are to be provided to residents who have been abused/neglected or allegedly abused/neglected. [LTCHA 2007, O. Reg. 79/10, s. 96 (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 with LTCHA 2007, O. Reg. 79/10, s. 96 (a), (e)to ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents contains procedures and interventions to assist and support residents who have been abused or neglected; and identifies the training and retraining requirements for all staff including (i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and (ii) situations that may lead to abuse and neglect and how to avoid such situations., to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents**

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

**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).**

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**Findings/Faits saillants :**

The Inspector reviewed the related Critical Incident on March 20, 2012 and noted that bruising to the resident's genitalia was first identified on February 11, 2012 at 15:30 hrs by the RPN. The critical incident report identified that the resident's Power of Attorney was "very upset that there was a delay from the staff in reporting the findings, the bruising discovered on Saturday evening and the family was not notified until Sunday afternoon".

The Inspector reviewed the home's corporate Resident Incident Report on March 20, 2012 which identified that the RPN observed bruising to the resident's genitalia while bathing the resident on February 11, 2012 at 15:30 hrs.

The RPN was interviewed by the Inspector on March 21, 2012 and reported that bruising to the resident's genitalia was observed while bathing the resident during the evening shift of February 11, 2012. The RPN estimated the resident was bathed between 15:15 - 15: 45 hrs and the RN was notified of the RPN's observations between 17:00 - 18:00 hrs.

A PSW was interviewed by the Inspector on March 23, 2012 and reported that with the assistance of a second PSW, the resident was transferred from the wheelchair to the tub chair and immersed into the bath water at which time the RPN entered the tub room and began to bathe the resident. The PSWs left the tub room. This PSW estimated that the resident was bathed between 15:35 - 15:45 hrs and reported being called back into the tub room approximately 15 minutes later by the RPN who alerted the PSW of bruising to the resident's genitalia.

The Inspector reviewed the resident's health care record on March 21, 2012 and noted that the resident's POA was notified of the resident's bruised genitalia on February 12, 2012 at 14:15 hrs by the RN.

The Inspector interviewed the resident's POA on March 21, 2012. The POA reported they were notified of bruising to the resident's genitalia "approximately 24 - 30 hours after the fact". The POA confirmed that they were very upset and disturbed that they were not immediately notified of bruising to the resident's genitalia.

The licensee failed to ensure that the resident's substitute decision-maker was 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 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 are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse of neglect of the resident. [LTCHA 2007, O. Reg. 79/10, s. 97. (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 with LTCHA 2007, O. Reg. 79/10, s. 97. (1) 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; and (b) are notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident., 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. 6. Plan of care**

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

**s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).**

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**Findings/Faits saillants :**

The resident's POA was interviewed by the Inspector on March 21, 2012 and reported that during the October 2011 admission of the resident to the home, the POA made a specific request regarding the provision of care to the resident. The POA identified that the request was made to the Resident Councillor. The POA reported that they were very upset to learn that their request was disregarded over the weekend of February 11-12, 2012.

The Resident Councillor was interviewed by the Inspector on March 22, 2012. The Resident Councillor recalled the conversation with the POA during the admission process of the resident in October 2011 and also recalled the POA's specific request regarding provision of care to the resident. The Resident Coucillor reported that it was the home's intent to facilitate the POA's request; however, the request was not transcribed into the resident's plan of care, leaving staff unaware of the POA's request. The Resident Councillor was unsure why the POA's wishes were not reflected in the resident's plan of care and believed it may have been a technical issue with the electronic documentation system. The Resident Councillor reported that an apology was offered to the POA for the documentation omission and reported that the POA's request is now documented in the resident's plan of care.

The Director of Nursing was interviewed on March 22, 2012 and confirmed that the POA's request was not complied with during the day shift of February 11. 2012.

The licensee failed to ensure that the resident's substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care. [ LTCHA 2007, S.O., c.8, s. 6 (5) ]

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.**

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**Findings/Faits saillants :**

The Inspector reviewed the Critical Incident on March 20, 2012 and noted that bruising to the resident's genitalia was first identified on February 11, 2012 at 15:30 hrs by the RPN.

The Inspector reviewed the home's corporate Resident Incident Report on March 20, 2012 and noted that the report was completed by the RPN who identified that they observed bruising to the resident's genitalia while bathing the resident on February 11, 2012 at 15:30 hrs.

The RPN was interviewed by the Inspector on March 21, 2012 and reported that bruising to the resident's genitalia was observed while bathing the resident during the evening shift of February 11, 2012. The RPN reported that the bath was conducted between 15:15 - 15: 45 hrs, the RN was notified of the RPN's observations between 17:00 - 18:00 hrs and the RN assessed the resident's bruised genitalia between 19:00 - 20:00 hrs.

A PSW was interviewed by the Inspector on March 23, 2012 and reported that with the assistance of a second PSW, the resident was transferred from the wheelchair to the tub chair and immersed into the bath water at which time the RPN entered the tub room and began to bathe the resident. The PSWs left the tub room. This PSW estimated that the resident was bathed between 15:35 - 15:45 hrs and reported being called back into the tub room approximately 15 minutes later by the RPN who alerted the PSW of bruising to the resident's genitalia.

The Assistant Director of Nursing (ADON) was interviewed by the Inspector on March 22, 2012. The ADON reported that they were contacted by the RN on the afternoon of February 12, 2012 at approximately 16:00 hrs and was notified of bruising to the resident's genitalia, the presence of the resident's POA at the home, that the POA was very upset with the delay in notification and that the POA was requesting access to the resident's health care record.

The Inspector reviewed the Critical Incident on March 21, 2012 and noted that the Elder Abuse Officer was notified of bruising to the resident's genitalia on February 13, 2012 at 10:02 hrs.

The Inspector contacted the Elder Abuse Officer on March 22, 2012. The officer confirmed they were notified of the resident's bruised genitalia by voicemail on February 13, 2012 at 1002 hrs and receipt of a follow up email on February 14, 2012.

The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. [LTCHA 2007, O. Reg. 79/10, s. 98 ]

***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 with LTCHA 2007, O. Reg. 79/10, s. 98 every licensee shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence., to be implemented voluntarily.***

**Issued on this 4th day of April, 2012**

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