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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 26, 2014	2014_214146_0012	H-000844-13	Critical Incident System

Licensee/Titulaire de permis

488491 ONTARIO INC
689 YONGE STREET, MIDLAND, ON, L4R-2E1

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

AVALON RETIREMENT CENTRE
355 BROADWAY AVENUE, ORANGEVILLE, ON, L9W-3Y3

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

BARBARA NAYKALYK-HUNT (146)

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): June 9, 10 , 11, 2014

This inspection was conducted concurrently with complaint inspection H-000677 -14, inspection #2014-214146-0011.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Education Coordinator, registered staff and Personal Support Workers (PSW's).

During the course of the inspection, the inspector(s) reviewed a resident's health record, the home's policy and procedure related to prevention of abuse, the home's internal investigation notes and the critical incident.

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

Findings of Non-Compliance were found during this inspection.

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the following rights of residents were fully respected and promoted: 2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
In December 2013, a resident expressed fear of a identified staff person to the home. This was confirmed in an interview with the nurse to whom the resident reported. The resident reported abuse. The identified staff person did work the following day, and according to Point of Care (POC) records, did provide care to the resident. According to the DOC, the identified staff person also worked another shift before being suspended pending investigation of the complaint. This information was confirmed by the health record and the DOC. The home did not ensure that the resident's right to be protected from abuse, in this case, emotional abuse and fear, was respected. [s. 3. (1) 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 the following rights of residents are fully respected and promoted: 2. Every resident has the right to be protected from abuse, to be implemented voluntarily.

WN #2: 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 did not ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with. 2007, c. 8, s. 20 (1).
According to the home's policy entitled "Resident Rights, Care and Services - Abuse - Zero Tolerance - Staff Acknowledgement", the most senior administrative staff member (or designate) who receives a report of resident abuse or neglect will: send an accused staff member home with pay pending completion of the investigation; and will promptly notify the administrator and/or DOC of the alleged abuse.
According to the home's policy entitled "Residents Rights, Care and services - Abuse", if the Administrator or DOC are not in the home, the charge nurse will notify the administrator, or if not available, the DOC.

In December 2013, a resident reported to the registered nurse in charge of the home physical abuse by a staff person. The charge nurse confirmed in an interview that an incident report was completed but the nurse did not attempt to notify the administrator or DOC. The accused staff person was not suspended from the workplace pending investigation and, according to Point of Care (POC)documentation, provided care to the resident on the day after the report. This information was confirmed by the charge nurse, the DOC, the home's internal investigation notes and the resident's health record. [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 to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee did not ensure that, (a) every alleged, suspected or witnessed incident of the following that the licensee knew of, or that was reported to the licensee, was immediately investigated: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff, or (iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
A resident reported to the home in December 2013 that the resident had been abused physically by an identified staff member. The home did not begin an investigation of the alleged abuse until 36 hours later. This information was confirmed by the health record, the home's internal investigation notes and the DOC. [s. 23. (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, (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff, or (iii) anything else provided for in the regulations, to be implemented voluntarily.

WN #4: 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.

Findings/Faits saillants :

1. The licensee did not ensure that the appropriate police force was immediately notified of the 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.
In December 2013, a resident reported to the home that the resident had been physically abused. The police were not notified immediately. According to the home's notes, the police were called five days later. This information was confirmed by the DOC and the health record. [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 to 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.

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. A person who had reasonable grounds to suspect that any of the following had occurred did not immediately report the suspicion and the information upon which it was based to the Director: 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.
A resident reported to the home in December 2013 that the resident had been physically abused by an identified staff person. The home did not report the alleged abuse to the Director immediately. The Critical Incident was sent in approximately 36 hours later. This information was confirmed by the records and the DOC. [s. 24. (1)]

WN #6: 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 did not ensure that the resident's substitute decision-maker and any other person specified by the resident, (a) were notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in a physical injury or pain to the resident or that caused distress to the resident that could potentially be detrimental to the resident's health or well-being.
A resident reported to the home in December 2013 that the resident had been physically. The SDM was not notified until 36 hours later, according to the critical incident, when a phone message was left for the SDM. This was confirmed by the DOC. [s. 97. (1) (a)]

Issued on this 27th day of June, 2014

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