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

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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 1, 2017	2016_334565_0013	027583-16	Resident Quality Inspection

Licensee/Titulaire de permis

BAY HAVEN NURSING HOME INCORPORATED
499 HUME STREET COLLINGWOOD ON L9Y 4H8

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

BAY HAVEN NURSING HOME
499 HUME STREET COLLINGWOOD ON L9Y 4H8

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

MATTHEW CHIU (565), JOVAIRIA AWAN (648), ROMELA VILLASPIR (653)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): September 12, 13, 14, 15, 16, 19, 20, 21, 22, and 23, 2016.

During the course of the inspection, the following Critical Incident Intakes were inspected: 034938-15 related to resident to resident abuse and 025141-16 related to staff to resident abuse.

During the course of the inspection, the following Complaint Intakes were inspected: 028548-15 related to staff qualification, 008430-16 related to pest control, and 010906-16 related to authorization for admission into a home.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing, Clinical Nurse Manager, Dietary Services Supervisor, Registered Dietitian, Activation Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Health Care Aides, Housekeeping Aides, Activities Aides, Residents, and Family Members.

The inspectors conducted a tour of the resident home areas, observations of medication administration, staff and resident interactions, provision of care, record review of resident and home records, meeting minutes for Residents' Council, menus, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Admission and Discharge
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Sufficient Staffing

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

10 WN(s)
5 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	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated, consistent with and complemented each other.

During transition of the Resident Quality Inspection (RQI), resident #003 was triggered related to an identified health condition.

Review of resident #003's dietary written plan of care indicated a specified amount for the resident's assessed daily fluid requirements.

Review of the fluid needs flow sheet for three identified months revealed another specified amount for resident #003's daily fluid requirements.

Interview with Registered Nurse (RN) #115 stated that it was his/her responsibility to update the fluid needs flow sheet, when the Registered Dietitian (RD) completed an assessment that resulted in changes to the daily fluid requirements for the resident. He/She further acknowledged that the RD had assessed resident #003's daily fluid requirements to be the specified amount that stated in the plan of care and that RN #115 had been calculating resident #003's daily fluid requirements based on the another specified amount and not as assessed by the RD. Record review of resident #003's written plan of care history revealed the another specified amount was resident #003's initial daily fluid requirement assessed by the Dietary Services Supervisor (DSS) shortly

after admission, about two years ago.

Interview with the RD stated that resident #003 was considered at nutrition risk. RD further indicated that the fluid needs flow sheet had not been updated, and that the expectation was for the night registered staff to update the flow sheet once a month based on the resident's written plan of care.

During an interview, the DSS acknowledged that collaboration did not occur between the dietary and nursing departments regarding the change in resident #003's daily fluid requirements. The DSS further indicated that changes concerning a resident should be communicated between departments.

There was no information obtained to indicate collaboration occurred between the nursing and dietary departments to address the change in resident #003's assessed daily fluid requirements. [s. 6. (4) (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 staff and others involved in the different aspects of care collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Review of MediSystem Pharmacy's policy titled "Inventory Control – Drug Disposal" Index Number 02-06-20 last reviewed on October 1, 2012, under the disposal of discontinued/expired medications section, item #1 (d) stated: "The following medications will be identified, destroyed and disposed of including: Medications that are no longer required due to being discontinued, or when a resident is discharged or deceased".

On September 16, 2016, the inspector observed a small container of an identified drug on resident #020's bedside table.

Review of progress notes indicated that the identified drug was discontinued by the physician on an identified date.

Interview with Registered Practical Nurse (RPN) #100 stated that the drug was discontinued on the identified date and it should have been discarded immediately after it was discontinued. The RPN removed the identified drug from resident #020's room afterwards.

Interview with the Director of Nursing (DON) stated that drugs should be discarded once they were discontinued by the physician. [s. 8. (1) (b)]

2. Review of MediSystem Pharmacy's policy titled "Medical Directives" last reviewed on June 23, 2014, under the policy section, item #4 stated: "The nurse will record the administration of a medication from the Medical Directives list that is approved for that

individual resident on the Medication Administration Record/eMar. The information to be recorded includes:

a. date and time
b. drug name
c. drug strength
d. route of administration, followed by "given as medical directive"
e. nurse's signature".

On September 16, 2016, inspector #653 and RPN #100 observed that two identified drugs were found in resident #003 and #020's bedside tables respectively.

Interview with resident #003 indicated that he/she used the identified drug daily.

Review of resident #003 and #020's three month drug review revealed the orders to continue with Guidelines For Care (GFC). Orders for the identified drugs included in the GFC had been in effect for these two residents on two identified dates respectively.

Review of resident #003 and #020's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for an identified month did not indicate an entry for the identified drugs for these two residents.

Interview with RPN #100 stated that the above mentioned drugs were ordered by the physician based on the residents' individualized GFC which was the home's medical directives. He/She further indicated that the order for the drugs should have been transcribed to resident #003 and #020's TARs before the drugs were provided to the residents.

Interview with the DON stated that drugs ordered by the physician under the GFC should be transcribed to a resident's MAR or TAR before administration. He/She further indicated that the home's expectation was for the GFC drugs to be transcribed on residents' MAR or TAR as directed by the policy on medical directives. [s. 8. (1) (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 policy on inventory control-drug disposal and medical directives put in place is complied with, to be implemented voluntarily.

WN #3: 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 has failed to ensure that residents were protected from abuse by anyone.

Review of a Critical Incident System (CIS) report and the progress notes indicated that on an identified date, RN #119 observed resident #011 demonstrated inappropriate responsive behaviours towards resident #009.

Inspector #653 attempted to interview resident #009, however, he/she was unable to recall details of the incident due to cognitive impairment.

Interview with RN #119 stated that he/she could not recall the incident. Inspector #653 attempted to interview the DON previously employed in the home at the time of the incident, but was unable to speak to him/her. The incident above mentioned incident could not be validated by staff interview at the time of this inspection.

Further review of resident #009's progress notes revealed an incident occurred nine days later that Personal Support Worker (PSW) #106 observed resident #011 demonstrated another inappropriate responsive behaviour towards resident #009.

Review of resident #009's written plan of care and interviews with RPN #100, RN #120, and the Activation Coordinator (AC) revealed that resident #009 had cognitive impairment and identified responsive behaviours.

Interview with resident #011 revealed that he/she could not recall the above mentioned incidents.

Interview with PSW #106 stated that the above mentioned second incident had happened and resident #009 responded in a way that suggested a state of shock. PSW #106 removed resident #009 from the situation and notified RN #120.

Interview with RN #120 stated that he/she assessed resident #009 and no injuries were noted.

Interviews with PSW #106 and RN #120 indicated that the incident was considered abuse.

During an interview, the DON acknowledged that the incident was an abuse, and that the home did not protect resident #009 from abuse. [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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

During transition of the RQI, resident #002 was triggered for inspection that related to falls. A review of resident #002's plan of care and progress notes revealed the resident was at risk for falls. The resident fell on two identified dates and sustained no injury. A review of the home's policy entitled "Falls Prevention and Management", last updated in February 2016, indicated the home uses a "Fall Risk Assessment" in PCC to assess a resident after each fall. A review of resident #002's post-fall assessment records indicated a post-fall assessment had not been completed for the resident's second fall.

Interview with RN #104 indicated when a resident falls, the post-fall assessment in PCC should be completed by a registered staff on the same shift or the next shift. Interviews with RN #104 and the DON confirmed that resident #002 fell on the above mentioned dates and a post-fall assessment had not been conducted for the second fall using the Fall Risk Assessment as required. [s. 49. (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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administered a drug to himself or herself unless the administration had been approved by the prescriber in consultation with the resident.

On September 16, 2016, the inspector and RPN #100 observed that two identified drugs were found in resident #003 and #021's bedside tables respectively.

Review of resident #003 and #021's three month drug review and the succeeding physician orders did not indicate the orders for the residents to self-administer the identified drugs.

Interview with RPN #100 stated that resident #003 and #021 did not have a physician order to self-administer the identified drugs. RPN #100 stated that he/she will follow-up with the physician regarding the order to self-administer drugs for residents #003 and #021.

Review of MediSystem Pharmacy's policy titled "Resident Self-Administration" Index Number: 04-01-30 last reviewed on October 1, 2012, under item #1 stated: "Residents may self-administer their medications only upon a physician's order in a nursing home".

Interview with the DON stated that registered staff were required to complete an assessment and obtain a physician's order for residents who self-administered drugs. [s. 131. (5)]

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 no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #6: 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 the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The licensee submitted a CIS report for reporting alleged staff to resident abuse on an identified date for residents #001, #030, #031 and #032.

Record review of the home's policy titled "Zero Tolerance of Resident Abuse and Neglect" last updated July 2016, identified that on becoming aware of abuse or suspected abuse, the first person having knowledge shall immediately inform the charge nurse on duty. Further record review of the home's policy titled "Staff Reporting and Whistle Blowing Protection and Mandatory Reporting" identified that all reports under that policy should be to a staff member's immediate supervisor or manager.

Interview with PSW #114 revealed on an identified date, he/she had witnessed Activities Aide (AA) #131 demonstrated an identified inappropriate interaction with resident #030 and that he/she considered as abuse. PSW #114 revealed he/she had spoken to PSW #106 after witnessing the interaction between AA #131 and resident #030, and confirmed he/she had not reported the incident to the charge nurse on duty that shift.

Interview with PSW #106 revealed he/she witnessed AA #131 demonstrated an identified inappropriate interaction with resident #032. PSW #106 revealed he/she had spoken to PSW #111 about witnessing this incident and his/her concerns related to AA #131's interaction with other residents. Interview with PSW #106 confirmed he/she had not reported the incident to the charge nurse on duty that shift.

Interview with PSW #111 revealed he/she had witnessed AA #131 demonstrated an identified inappropriate interaction with resident #031 on the identified date. As a result, resident #031 appeared to be in distress.

Interview with PSW #111 further revealed he/she had witnessed AA #131 demonstrated an identified inappropriate interaction with resident #001 on the identified date. PSW #111 further indicated he/she considered this incident as abuse.

PSW #111 reported his/her concerns to AA #117 related to the witnessed incidents, as well as the concerns PSW #106 had discussed with him/her regarding AA #131. PSW #111 had not reported his/her concerns to the charge nurse.

Interview with the DON revealed the home's process for reporting alleged, suspected, or witnessed abuse required staff to report right away to the department head, supervisor, charge nurse, or the DON directly.

PSWs #111, #114 and #106 failed to report suspected, alleged, or witnessed abuse to their immediate manager, supervisor, charge nurse, or the DON, and therefore failed to comply with the home's written policy. [s. 20. (1)]

2. Review of the home's policy titled "Zero Tolerance of Resident Abuse and Neglect" last reviewed on July 2016, under procedure for investigating and responding, item #3 stated: "The Charge Nurse or person discovering the abuse or neglect shall report the matter to the Director of Nursing/designate or Administrator immediately and complete the Resident Abuse & Neglect Reporting Form (located in filing cabinet at Nursing Station) including what occurred; when it occurred; who was involved, including witnesses; where it occurred and the names of those in the vicinity who may be witnesses".

Review of progress notes indicated that on an identified date, resident #011 was seen demonstrating an identified inappropriate responsive behaviour towards resident #009.

Interview with PSW #106 stated that he/she witnessed the incident and considered it as abuse. PSW #106 further indicated that he/she had immediately reported it to RN #120.

Interview with RN #120 stated that the incident was considered as abuse. He/She also stated that after PSW #106 notified him/her of the incident, RN #120 immediately reported it to the charge nurse, RN #121.

Interview with RN #121 indicated that PSW #106 notified him/her of the incident, and that RN #121 considered it as abuse. RN #121 further indicated that he/she did not document about the incident.

RN #120 stated that RN #121 did not complete an incident report, and there was no documentation to indicate the incident had been reported to the DON/designate or the Administrator. RN #120 further indicated that it should have been reported to the DON.

Interview with the DON stated that the incident had not been reported to the management team, and that the home's expectation was for staff to immediately report incidents of abuse to the DON. [s. 20. (1)]

WN #7: 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 a person who had reasonable grounds to suspect that abuse of a resident had occurred must immediately report the suspicion and the information upon which it was based to the Director.

The licensee submitted a CIS report for reporting alleged staff to resident abuse on an identified date for residents #001, #030, #031 and #032.

Interview with PSW #114 revealed on an identified date, he/she had witnessed AA #131 demonstrated an identified inappropriate interaction with resident #030 and that he/she

considered as abuse. PSW #114 revealed he/she had spoken to PSW #106 after witnessing the interaction between AA #131 and resident #030 but did not report the incident to management.

Interview with PSW #106 revealed he/she witnessed AA #131 demonstrated an identified inappropriate interaction with resident #032. PSW #106 was unable to recall the definitive date of the incident, but revealed he/she had spoken to PSW #111 about witnessing this incident and his/her concerns related to AA #131's interaction with other residents. Interview with PSW #106 confirmed he/she had not reported the incident to the charge nurse on duty that shift.

Interview with PSW #111 revealed he/she had witnessed AA #131 demonstrated an identified inappropriate interaction with resident #031 on the identified date. PSW #111 stated he/she had reported his/her concerns to AA #117 related to the witnessed incidents regarding AA #131.

Interview with AA #117 confirmed PSW #111 reported the above mentioned incident to him/her. AA #117 stated he/she reported the information to his/her supervisor, the AC immediately in the same day.

Interview with the AC confirmed that AA #117 had reported the incidents to him/her and that he/she reported this information to the DON as soon as becoming aware of the suspected abuse in the same day.

Interview with the DON revealed that the AC reported the suspected abuse to him/her on the identified date. The DON indicated the home submitted a CIS report related to the witnessed abuse to the Director four days later. The DON confirmed the home had not submitted the report regarding the suspected abuse and the information upon which it was based to the Director immediately upon becoming aware of it. [s. 24. (1)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Findings/Faits saillants :

1. The licensee has failed to approve the applicant's admission to the home unless, (a) the home lacks the physical facilities necessary to meet the applicant's care requirements; (b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or, (c) circumstances exist which are provided for in the regulations as being a ground for withholding approval.

Record review of a letter for withholding admission revealed an admission application was withheld by the home because the home does not have the necessary resources to meet the applicant's care needs. The letter states that the applicant has identified responsive behaviours and cannot be adequately monitored to ensure the applicant's safety.

Review of the applicant's Behavioural Assessment Tool indicated the applicant has the identified responsive behaviors which can be managed easily.

The home had an identified list indicating residents with the identified responsive behaviours. A review of the list indicated an identified number of residents were on the list.

Interview with RN #104 indicated the residents on the list had the identified responsive behaviours. The home had implemented individualized plans of care to manage these residents' behaviours, and they had been effective.

Interview with the DON indicated the home has residents demonstrating the identified responsive behaviours. Care and strategies had been implemented to ensure the residents' care needs and safety were met. Furthermore, the home has registered staff available for conducting behavioural assessments using the P.I.E.C.E.S. approach and has referral protocol for external resources to deal with residents with complex behavioural needs. The DON confirmed the applicant's care requirements would be met by the home and the application should not be withheld. [s. 44. (7)]

WN #9: 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 notify the resident's substitute decision-maker (SDM) and any other person specified by the resident within 12 hours upon becoming aware of the alleged, suspected or witnessed incident of abuse of the resident.

The licensee submitted a CIS report on an identified date for reporting alleged staff to resident abuse that had happened to residents #001, #030, #031 and #032 four days before.

Review of the CIS report did not indicate that the residents' SDMs had been contacted by the home notifying them of the alleged abuse.

Record review of the home's policy titled "Zero Tolerance of Resident Abuse and Neglect" last updated July 2016, indicated that on becoming aware of abuse or suspected abuse, the DON will notify the SDM within 12 hours of any alleged, suspected, or witnessed incident of abuse or neglect involving a resident.

Review of the progress notes for residents #001, #030, #031, and #032 revealed there was no documentation of notification to an SDM or person specified by the resident regarding the alleged abuse.

Interview with the DON revealed he/she became aware of the suspected abuse and the information upon which it was based on the identified date. The DON further confirmed the home had failed to contact the SDM or designate for the residents identified in the CIS report within 12 hours of becoming aware of the alleged abuse for each resident. [s. 97. (1) (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that in making a report to the Director under subsection 23 (2) of the Act, the following material in writing was included: A description of the individuals involved in the incident, including names of any staff members or other persons who were present at or discovered the incident, and names of staff members who responded or are responding to the incident.

The licensee submitted a CIS report on an identified date reporting incidents of alleged staff to resident abuse that had happened to residents #001, #030, #031 and #032 four days before. The CIS report submitted to the Director identified PSW #111 and #114 as the staff who were present and/or discovered the incident. The report did not identify the alleged staff member.

Interviews with PSW #111 and #114, and the DON revealed that PSW #106 was present at the time of one of the incidents related to resident #031 as identified in the CIS report. Interviews with PSW #106, #111, #114, AA #117, the AC and the DON confirmed the alleged staff member as AA #131.

Interview with the DON confirmed that all identified staff members involved in the incidents of alleged abuse, including the alleged staff, had not been included in the CIS report submitted to the Director. [s. 104. (1) 2.]

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

Issued on this 16th day of February, 2017

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

Original report signed by the inspector.