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 sions 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
May 2, 2016	2016_189120_0024	011674-16/010967-16	Critical Incident System

Licensee/Titulaire de permis

THE CENTRAL CANADIAN DISTRICT OF THE CHRISTIAN AND MISSIONARY ALLIANCE IN CANADA
155 PANIN ROAD BURLINGTON ON L7P 5A6

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

CAMA WOODLANDS NURSING HOME
159 PANIN ROAD BURLINGTON ON L7P 5A6

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

BERNADETTE SUSNIK (120)

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): April 28, 2016

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Administrator and Director of Care.

During the course of the inspection, the inspector toured the 1st floor balcony and outdoor area on the ground floor, reviewed the home's prevention of abuse policy, employee and resident interview statements, employee abuse education and training attendance records and an identified employee's records.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

The licensee did not ensure that there was a written policy that dealt with when doors leading to secure outdoor areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

The home was equipped with two balconies and an enclosed outdoor space for resident use. The licensee did not have a written policy for review that identified when the doors to the outdoor space or the balconies would be kept unlocked and what if any supervision was required for the various outdoor spaces. On an identified date in April 2016, a balcony on the ground floor that overlooked a landscaped hill and service driveway was left unlocked during the day to allow residents freedom to gain access to the balcony. A resident entered the balcony and climbed up onto the hand railing surrounding the balcony enclosure which was approximately 5 feet 8 inches high and climbed over the top of the enclosure which was made of metal and tempered glass. The resident dropped down onto the ground which was approximately 7 feet below. The resident was seen outside on the grounds by a staff member and returned unharmed. Discussion was held with the administrator regarding the need to assess the risks associated with each type of outdoor space and whether residents would require any type of monitoring while using outdoor spaces and when doors to these spaces would be locked or unlocked. [s. 9. (2)]

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 :

The licensee did not ensure that the written policy that promoted zero tolerance of abuse of residents was complied with.

The licensee's abuse policy 07-01-01 titled "Resident Rights and Safety - Zero Tolerance Policy" defined verbal abuse to include yelling, intimidation, humiliating comments, ridicule and inappropriate ultimatums or refusals to provide assistance. The policy stated that all staff must report any incident or suspected incident of resident abuse to the appropriate sources such as a manager. The policy also required that the administrator or designate report to the Director (Ministry of Health) within 24 hours of starting the investigation which indicated that a resident suffered abuse or had likely suffered from abuse.

According to the administrator, employee interview records and information provided in the critical incident report submitted in April 2016, resident #101 was verbally abused by PSW #200 on two specific dates in March and April 2016. While the PSW was in the resident's room, another PSW (#201) overheard her talking to the resident in a loud voice that "she would not take care of the resident anymore and was taking too much of her time". In April 2016, PSW #200 was overheard by PSW #202 stating the same thing in a loud voice. Neither PSW reported the incident to a manager. Three days after the incident in April 2016, the resident reported to PSW #203 that PSW #200 yelled at the resident, told them that she wouldn't lay out their clothes and that they were too fussy and that made the resident cry. PSW #203 reported the allegation to the registered staff as required. The registered staff member reported the allegation to the Director of Care the following day. The Director of Care (DOC) and Administrator immediately investigated the allegation of verbal abuse which was determined to have been founded. Appropriate follow up actions were taken. However, the DOC did not immediately report their suspicion of verbal abuse to the Director until 2 days after being notified by the registered staff member. According to the DOC, they thought that they needed to confirm through their investigation whether abuse actually occurred before reporting the matter to the Director. [s. 20. (1)]

Issued on this 3rd day of May, 2016

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

Original report signed by the inspector.