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

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jan 10, 12, 16, 23, 24, 25, 30, 2012	2012_031194_0003	Critical Incident

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (PORT PERRY)
15941 Simcoe Street, Port Perry, ON, L9L-1N5

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

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care, Two Resource Nurses, Educational Coordinator, Activity Director, Director of Nursing Services for Quality Risk, three Registered Practical Nurses, Personal Support Workers and three Residents

During the course of the inspection, the inspector(s) reviewed the licensee's internal investigation reports, resident's clinical records, Resident Council Minutes, Licensee's Abuse Policy RSL-RR-010, three critical incident reports and educational records for staff. During the course of the inspection the inspector conducted three Critical Incident Inspections related to Log # 002778-11;Log# 002851-11; and Log # 002265-11.

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	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following subsections:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. Review of Abuse Policy RSL-RR-010 staff to resident and competent resident to another resident, dated July 25, 2011 indicates that:

There is no program, that complies with the regulations, for preventing abuse and neglect, or

an explanation of the duty under section 24 to make mandatory reports [s.20.(2)(c)(d)](refers to Log # 002265-11, 002778-11 and 002851-11)

WN #2: 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 subsections:

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;
(b) appropriate action is taken in response to every such incident; and
(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).

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

A Critical Incident was forwarded to the Director in December, 2011 with the initial details to the alleged abuse situation. The Licensee's investigation was completed and as of January 16, 2011 no results of the investigation undertaken had been forwarded to the Director.[s.23.(2)] (refers to Log # 002778-11)

A Critical Incident was forwarded to the Director in December, 2011 with the initial details to the alleged abuse situation. The Licensee's investigation was completed and as of January 16, 2011 no results of the investigation undertaken had been forwarded to the Director.[s.23.(2)](refers to Log # 002851-11)

A Critical Incident was forwarded to the Director in October, 2011 with the initial details to the alleged abuse situation. The Licensee's investigation was completed and as of January 16, 2011 no results of the investigation undertaken had been forwarded to the Director. [s.23.(2)](refers to Log # 002265-11)
2. The licensee's Abuse Policy RSL-RR-010 dated July 25, 2011 states that;

"All alleged/actual cases of abuse will be recognized, reported and investigated".

The licensee failed to comply with it's Abuse Policy when, a Registered Practical Nurse and a, Registered Nurse, supervising a Personal Support Worker, became aware of abuse behavior towards residents and did not recognize, report or investigate. (refers to Log # 002778-11 and Log # 002851-11)

The licensee's Abuse Policy RSL-RR-010 states that;

The Administrator, Director of Care or designate will immediately initiate an investigation upon receiving a report of alleged, actual or suspected abuse"

In October, 2011 a Registered Nurse, was providing care to an identified resident. A visitor witnessed and was concerned about the rough manner in which the nurse was providing the care to a resident. The visitor confronted the Nurse about her behaviour. The nurse notified the Director of Care, and was directed by Director of Care to get contact information from visitor so that she could follow up with the concerns. The Director of Care did not initiate the follow up until 12 days later. [s.23.(1)(a)] (refers to Log # 002265-11)

The licensee did not comply with the legislation and failed to follow it's Abuse Policy, when the Director of Care did not immediately initiate an investigation into the visitor's concern expressed about the care provided by the Nurse to the resident.[s.23.(1)(a)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following subsections:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The inspector interviewed two Registered Nurses and three Practical Registered Nurses, all staff interviewed stated that they had not received education in mandatory reporting under section 24.[76(2)4]

WN #4: 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.

Findings/Faits saillants :

The Educational Coordinator indicated that;
- 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
- situations that may lead to abuse and neglect and how to avoid such situations.
are not included in the training/education that is provided for the staff. The above listed items are not provided for in the licensee's Abuse policy RSL-RR-010.[s.96.(e)(i)(ii)](refers to Log # 002265-11, 002778-11 and 002851-11)

WN #5: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The plan of care for an identified resident with responsive behaviours had intervention listed for resident care, to be followed by staff.

In October, 2011, a Registered Nurse failed to provide care as set out in the plan of care when;

An identified resident with responsive behaviours exhibited agitation, resistive care and anxiety and the nurse did not follow the interventions provided in the plan of care to deal with these behaviours.(refers to Log # 002265-11)

The care set out in the plan of care was not provided to the resident in October, 2011 as specified in the plan, when nurse failed to, leave and return to the resident when resistive behaviour was noted, when nurse did not leave and invaded the resident's space when exhibiting signs of agitation, when nurse failed to call the family in attempts to calm the resident.

WN #6: 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 :

An identified resident stated to the inspector that an identified Personal Support Worker (PSW) provided care in a rough manner. The identified resident stated that this staff's behaviour had been ongoing for a long period of time.

An identified resident stated to the inspector that an identified Personal Support Worker, appeared not to care, and that the tone of voice and attitude during care were not appropriate.

An identified resident stated to the inspector that the Personal Support Worker, would come in and shut buzzer off and would not come back. The staff would swat the resident's bottom with the incontinent product, and was rough while providing care. The resident stated that this staff's behaviour had been ongoing for a long period of time. (refers to Log # 002778-11 and Log # 002851-11)
Review of statements provided by Registered Practical Nurse supports that the Personal Support Worker, was neglecting the care of the residents and verbally abusing them. This abuse had been happening for a period of time.

Interview conducted by Inspector with Registered Practical Nurse confirms above statement.

Review of statements provided by Registered Nurse, states she had witnessed many times that the Personal Support Worker had spoken to residents in a loud, short tempered manner.

The above identified, Registered Nurse and Registered Practical Nurse, were aware of Personal Support Worker's, verbally abusive manner towards residents and did not report to their supervisors.(refers to Log # 002778-11, 002851-11)
3. The investigation conducted by the licensee in regards to the allegations brought forward by residents, about the care provided by the Personal Support Worker, found the staff member to be in violation of the Abuse Policy.

The Licensee failed to meet the legislative requirements, where a person who has reasonable grounds to suspect that 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 resident is immediately reported to the director.[s.24(1)2]

Issued on this 30th day of January, 2012

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

Chantal Lafreniere (194)