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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Jun 14, 19, 22, Aug 17, Sep 7, 2012	2012_027192_0033	Critical Incident

Licensee/Titulaire de permis

DELHI NURSING HOME LTD
750 GIBRALTAR STREET, DELHI, ON, N4B-3B3

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

DELHI LONG TERM CARE CENTRE
750 GIBRALTAR STREET, DELHI, ON, N4B-3B3

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

DEBORA SAVILLE (192)

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, Assistant Director of Care, Registered Nurses, Registered Practical Nurses, Director Policy and Legislation, Personal Support Workers, and residents related to H-000879-12.

During the course of the inspection, the inspector(s) reviewed medical records, incident reports and policy and procedure.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. Previously issued January 6, 2011 and June 13, 2011
The licensee failed to ensure that the resident is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary. [s. 6. (10) (b)]

a) Resident 001 was observed touching a resident without consent in 2012. No assessment of this behaviour was completed and the plan of care was not updated until after a second incident occurred in 2012.
The Minimum Data Set (MDS) Resident Assessment Protocol (RAP) complete in 2012 did not include the presence of this new behaviour. Interventions were not put in place to protect resident 002.

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 ensuring that the resident is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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 subsections:

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 failed to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home. [s. 19. (1)]

a) Resident 001 was observed touching a resident in a sexual manner without consent in 2012. The plan of care was not modified to identify this as a potential behaviour for resident 001 for a five month period in 2012.

b) In 2012 resident 002 was observed walking in the corridor. Resident 001, was walking toward resident 002, followed by a Personal Support Worker, who observed resident 001 reach out and touch resident 002.

c) Resident 002 expressed anxiety about having been touched without prior consent in 2012.

d) The licensee failed to protect resident 002 from abuse by resident 001 who had previously exhibited similar behaviour with another resident of the home.

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 ensuring that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, 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 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).

Findings/Faits saillants :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported, is immediately investigated. [s. 23. (1) (a)]

a) Resident 001 touched a co-resident without consent in 2012. Interview confirms that no investigation into the incident has conducted.

b) Resident 001 touched a female resident without consent in 2012. The Director of Care was made aware of the incident on the day of the incident. Interview confirms that no investigation was conducted into the incident, immediately upon becoming aware of the incident.

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 ensuring that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported is immediately investigated, to be implemented voluntarily.

WN #4: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were notified within 12 hours upon becoming aware of a witnessed incident of abuse. [r. 97. (1) (b)]

a) In 2012 resident 002 sustained non-consensual touching that caused anxiety for resident 002.

b) The Director of Resident Care was aware of the witnessed incident in 2012, but the SDM was not until the Executive Director was made aware of the incident.

c) The SDM for resident 002 was not notified of an incident of abuse within 12 hours upon becoming aware of the incident.

WN #5: 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 subsections:

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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with. [r. 8. (1)]

The home's policy on Multidisciplinary Documentation reference number 009060.00 states that:
PSW (Personal Support Worker) staff will document on POC (Point of Care) as close to the time of completion of task as possible. Do not bulk chart for tasks. Timed tasks must be documented as close to the time of the event as possible.

a) Resident 001 was to be monitored every 30 minutes and documentation on Point Of Care (POC) completed. Personal Support Worker (PSW) staff did not consistently document that the task was completed at the time that monitoring was to have been completed and on several occasions, multiple monitoring periods were documented at the same time.

On May 7, 2012 monitoring was documented for 1230, 1300 and 1330 at 1333. On May 11, 2012 monitoring was documented for 0600, 0630, 0700 and 0730 at 0923. On May 12, 2012 monitoring was documented for 0600, 0630, 0700 and 0730 at 0750. On May 13, 2012 monitoring was documented for 0600, 0630, 0700 and 0730 at 0845 and for 00800, 0830 and 0900 at 0921.

Interview confirms that the shift change occurs at 0630 and the staff member documenting at 0923 would not be the same staff member caring for the resident at 0600.

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 :

1. Any person who had reasonable grounds to suspect that abuse has occurred or may occur, failed to immediately report the suspicion and the information upon which it was based to the Director.

a) In 2012 resident 001 was observed by a Personal Support Worker, to touch resident 002 without consent. Documentation and interview indicate that resident 002 expressed anxiety following the incident.

b) Staff were aware of the incident on the day that it occurred, the Director of Resident Services did not notify the Director of the incident. The Executive Director of the home was notified the following day. The Director was not notified immediately. The Emergency Pager was not called to report this witnessed incident of abuse.

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 ensuring that any person who has reasonable grounds to suspect that sexual abuse has occurred or may occur, immediately reports the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/ LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

CORRECTED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 r. 15.	CO #001	2011_066107_0003	192
O.Reg 79/10 r. 110.	CO #002	2011_066107_0003	192

Issued on this 12th day of September, 2012

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