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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 23, 2019	2019_773155_0011	012035-19	Complaint

Licensee/Titulaire de permis

Corporation of the County of Dufferin
151 Centre Street SHELBURNE ON L9V 3R7

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

Dufferin Oaks
151 Centre Street SHELBURNE ON L9V 3R7

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

SHARON PERRY (155), TAWNIE URBANSKI (754)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 10, 11, 12 and 15, 2019. Offsite telephone interviews were also done on July 18 and July 25, 2019.

A complaint related to alleged resident to resident abuse was completed during this inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Behaviour Support Lead RPN, Social Worker, Personal Support Workers (PSW), residents and family.

During the inspection the inspectors toured three resident living areas; observed staff to resident interactions, resident to resident interactions; reviewed relevant clinical records, policies and procedures; and observed the general maintenance and cleanliness and condition of the home.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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	Légende 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. 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 failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knew of, or that was reported was immediately investigated.

On an identified date, the Ministry of Long Term Care received a complaint regarding alleged resident to resident abuse..

Review of an identified residents' progress notes stated that on an identified date there was an alleged incident between two residents.

Director of Care #100 shared that there was no investigation of the alleged incident.

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that for each resident demonstrating responsive behaviours that strategies were developed and implemented to respond to these behaviours, where possible, and actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to the interventions were documented.

On an identified date, the Ministry of Long Term Care received a complaint regarding alleged resident to resident abuse.

Review of an identified resident's progress notes showed the following:

On an identified date, resident #002 demonstrated a responsive behaviour towards resident #001.

On six identified dates, resident #002 demonstrated responsive behaviours towards resident #003.

Review of resident #002’s care plan identified that resident #002 had responsive behaviours.

PSW #104 shared that resident #002 had responsive behaviours and the interventions were not always effective.

RPN/Behaviour Support Lead #105 shared that resident #002 had been seen in the past and triggers of behavior were identified and interventions put in place. Resident #002 was not followed by Behaviour Support Lead #105 until a referral on an identified date, where resident #002 demonstrated responsive behaivours towards resident #001. They acknowledged that resident #002 did have responsive behaviours and had not had any recent assessments or referrals to any outside psychogeriatric resources.

Director of Care #100 shared that the interventions to deal with resident #002’s responsive behaviours were in the care plan.

Resident #002's plan of care was reviewed and the interventions identified for their responsive behaviors were limited and did not address the responsive behaviours exhibited towards resident #001 and #003.

The licensee failed to ensure that when resident #002 demonstrated responsive behaviours that strategies were developed and implemented to respond to these behaviours, where possible, and actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to the interventions were documented. [s. 53. (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 for each resident demonstrating responsive behaviours, that strategies are developed and implemented to respond to these bebaviours, where possible; and actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that ther resident's responses to interventions are documented, to be implemented voluntarily.

WN #3: 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 who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm shall report the suspicion and the information upon which it was based to the Director.

On an identified date, the Ministry of Long Term Care received a complaint regarding alleged resident to resident abuse.

Director of Care #100 and Administrator #101 shared that they were aware of the incident.

Director of Care #100 shared that that this incident was not reported to the Director.

The licensee failed to report the incident of alleged abuse of resident #001 by resident #002. [s. 24. (1)]

Issued on this 23rd day of August, 2019

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

Original report signed by the inspector.