Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jan 27, 2020	2020_739694_0001	018819-19, 020297-19, 020378-19, 021509-19, 023569-19, 023946-19	Critical Incident System

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

AMANDA COULTER (694), LUCIA KWOK (752)

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): January 7, 8, 9, and 10, 2020.

The following intakes were completed in this Critical Incident Systems (CIS) inspection:
Log #018819-19, Log #020297-19, Log #020378-19, and Log #021509-19, related to fall prevention.
Log #023569-19, and Log #023946-19, related to alleged staff to resident abuse.

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

During the course of the inspection, the inspectors toured the home, observed the provision of care and services, reviewed relevant documents, including but not limited to clinical records, policies and procedures, internal investigation notes, training records and meeting minutes.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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. 6. Plan of care

Specifically failed to comply with the following:

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 :

1. The licensee has failed to ensure the care set out in the plan of care was provided to resident #001 as specified in the plan.

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) related to a specific resident's fall resulting in a medical injury.

The resident's Incident Report/Post Fall Assessment was reviewed. It stated that direct care staff found the resident on the floor. It was documented that one of the contributing factors was that a fall prevention safety device was not activated.

The resident's plan of care stated that they were at high risk of falls and specific safety devices were put in place.

An observation was completed by Long-Term Care Home (LTCH) Inspector #752 that showed that the resident's safety device was not turned on.

The licensee failed to ensure that care was provided to a specific resident, specifically the safety devices were in place, as specified in the care plan. [s. 6. (7)]

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 the care set out in the plan of care is provided to residents, as specified in the plan, 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:

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 were protected from abuse by anyone.

A CIS report was submitted to the Director regarding alleged verbal abuse of two residents, by a staff member.

For the purposes of the Act and this Regulation, "verbal abuse" means, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

A) A specific resident was scheduled to have a shower, a staff member was overheard telling the resident to have a bowel movement so they would not have to clean them up later.

B) Another resident was incontinent and had a bowel movement, the staff member was overheard asking the resident why they put their hands in their bowel movement and now they would have to clean them.

The two incidents were reported immediately to management in the home and investigated.

In separate interviews with staff, they said the incidents did not have any impact on the residents as they were cognitively impaired and did not understand what was said to them.

The outcome of the licensee’s investigation determined the staff member was verbally abusive towards the two residents.

The licensee failed to protect residents from verbal abuse by a staff member. [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 #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of incidents that caused an injury to a resident for which the resident was taken to hospital and resulted in a significant change in the residents status, no later than three business days after the incident occurred.

A) A CIS report was submitted to the Director related to a resident that had a fall which required transfer to hospital. The resident had medical complications as a result of the fall.

Staff were unsure why the CIS was not submitted within the required three business days as they were aware there was a significant change in the resident’s health.

B) A second resident had a fall which required transfer to hospital for further medical assessment. Communication from the hospital and the resident’s SDM identified that the resident was admitted to hospital for further assessment and treatment.

A CIS report was submitted to the Director seven days after the fall and the resident was transferred to hospital. In an interview with staff, they said they did not submit a CIS sooner, as the home was unsure if there was a significant change in the resident's health status.

It was later determined the resident's fall and related injuries had significant impact on their activities of daily living (ADL) which required changes to the plan of care.

The licensee failed to ensure that the Director was notified within three business days when residents were taken to hospital, and sustained an injury that resulted in a significant change to their status. [s. 107. (3.1)]

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 where an incident has occurred that caused an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition and where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remained unsure whether the injury has resulted in a significant change in the resident's health condition, will inform the Director of the incident no later than three business days after the occurrence of the incident, to be implemented voluntarily.

Issued on this 29th day of January, 2020

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

Original report signed by the inspector.