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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Sep 12, 13, 17, 18, 19, 24, 2012	2012_128138_0029	Critical Incident

Licensee/Titulaire de permis

DUNDAS MANOR LIMITED
533 CLARENCE STREET, P.O. BOX 970, WINCHESTER, ON, K0C-2K0

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

DUNDAS MANOR NURSING HOME
533 CLARENCE STREET, P.O. BOX 970, WINCHESTER, ON, K0C-2K0

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

PAULA MACDONALD (138)

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, the Acting Administrator, the Director of Care, Nursing Manager, Recreation Manager, Office Manager, PSW's, residents, and a resident's family member.
The inspection occurred on-site September 12 and 13, 2012.

During the course of the inspection, the inspector(s) reviewed the home's abuse policy, critical incident report, internal investigation records, training and orientation documents, and a resident health record.

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. 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. The home failed to comply with LTCHA 2007 s. 24. (1) 2. in that persons who had reasonable grounds to suspect that abuse of a resident by anyone occurred did not immediately report the suspicion and the information upon which it is based to the Director.

A PSW alleged that s/he witnessed an incident of physical abuse on a day in April 2012 in that s/he observed a PSW punch a resident in the back three times while preforming care to the resident. The PSW who witnessed the incident confided in a third PSW two days later and the third PSW encouraged the PSW to report the incident immediately. The incident was not reported until a day in May 2012 when it was reported to the home's Nursing Manager. The home's management became aware of the incident of alleged physical abuse but the incident was not reported to the Director until five days after management became aware of the incident. The total time between the alleged witnessed incident of abuse and the time the incident was reported to the Director was eighteen days.

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 the information relating to a suspicion of abuse of a resident by anyone is immediately reported to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The home failed to comply with LTCHA 2007 s. 3. (1) 2. in that every resident has the right to be protected from abuse.

A PSW alleged that s/he witnessed a PSW punch a resident in the back three times on a day in April 2012 while preforming care for the resident. The resident's family member reported that the resident confirmed to him/her several days later that s/he was hit by a staff member on his/her back. The resident confirmed again to LTCH Inspector that s/he was hit by a staff member on his/her back. In addition, the home's Nursing Manager reported that the resident exhibited increased physical aggression correlating to the time of the alleged physical abuse incident to the extend that the physician ordered further medical interventions. The Nursing Manager further reported the resident's physical aggression decreased around the time that PSW who was alleged to hit the resident was reassigned from the resident's unit. A review of the resident's health care record confirmed the changes in behaviours and medical interventions.

The home has not taken any further actions to protect residents on other units from potential abuse by a PSW, who was alleged to abuse a resident, as directed by the home's abuse policy which states that corrective actions are to be taken even when there exists a strong suspicion, but no conclusive proof, that abuse has occurred.

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 resident has the right to be protected from abuse, to be implemented voluntarily.

WN #3: 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. The home failed to comply with LTCHA 2007 s. 20 (2) (b) (d) (f) and (h) in that the policy to promote zero tolerance of abuse and neglect of residents did provided for the following:

The home's abuse policy, Resident Abuse Policy - Nurs 1-160, provided by the Director of Care did not clearly define physical, emotional, or verbal abuse consistent with the definitions provided for in the regulations.

The policy did not contain an explanation of the duty to make mandatory reports that was consistent with s. 24 of the legislation.

The policy did not set out consequences for those who abuse or neglect residents.

The policy lacked procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected (s. 96 (a)).

The policy lacked procedures and interventions to deal with all persons who have abused or neglected or allegedly abused or neglected residents (96. (b)).

The policy's direction to inform the resident's substitute decision maker of an alleged, suspected or witnessed incident of abuse was not consistent with the regulations s. 97. (1) (a) and (b) nor was the policy's direction to notify the resident's substitute decision maker of the results of the investigation consistent with the regulation 97. (2).

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).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The home failed to comply with O. Reg 79/10 s. 97 (1) (a) in that the home did not notify the resident's substitute decision maker immediately upon the licensee becoming aware of any alleged incident of resident abuse that resulted in 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.

A PSW alleged that s/he witnessed a physical abuse incident from another PSW to a resident on a day in April 2012 in which a resident confirmed to LTCH Inspector that s/he was hurt by a staff member and that s/he is afraid to be in the home. The PSW who witnessed the incident confided in a third PSW two days later regarding the incident of alleged abuse and then further reported the incident to the home's Nursing Manager in May 2012. The substitute decision maker for the resident was not made aware of the incident of alleged abuse until later in May 2012, eighteen days after the alleged incident was witnessed and five days after the incident was reported to a home's manager.

2. The home failed to comply with O. Reg 79/10 s. 97.(2) in that the resident's substitute decision-maker was not notified of the results of the investigation into alleged resident abuse immediately upon the completion of the investigation.

The resident's substitute decision maker asked the home's Acting Administrator for the outcomes of the investigation in June 2012, approximately 1 month after the investigation was completed and in response the substitute decision maker was provided a modified copy of the home's critical incident report.

WN #5: 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. (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 :

1. The home failed to comply with LTCHA 2007 s. 23. (2) in that the home did not report the results of the investigation of abuse of a resident to the Director.

The home did submit a critical incident to MOHLTC in May 2012 regarding the incident of alleged abuse however the conclusions and any further actions taken as a result of the home's investigation were not reported to the Director.

Issued on this 24th day of September, 2012

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

JM McPaul signed for P. MacDonald