Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 27, 2016	2016_320612_0014	031167-15	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the City of Timmins
481 Melrose Blvd. TIMMINS ON P4N 5H3

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

GOLDEN MANOR
481 MELROSE BOULEVARD TIMMINS ON P4N 5H3

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

SARAH CHARETTE (612), TIFFANY BOUCHER (543)

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): May 16- 19, 2016.

This Critical Incident Inspection is related to the fall of a resident, improper care of a resident, alleged staff to resident abuse, alleged resident to resident abuse, and alleged visitor to resident abuse.

A Follow Up Inspection (#2016_320612_0013) and Complaint Inspection (#2016_320612_0012) were conducted concurrently to this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Resident Support Services Supervisor, Director of Nursing (DON), Nursing Care-Coordinator, Infection Prevention and Control Coordinator, Human Resources Administrator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and their family members.

The Inspector(s) conducted a daily walk through of resident areas, observed the provision of care towards residents, observed staff to residents interactions, reviewed residents' health care records, staffing schedules, staff training records, policies, procedures, programs, and staff personnel files.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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	Legendé 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:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

Inspector #543 reviewed a Critical Incident (CI), related to an alleged incident of abuse that occurred in March 2016, and was not reported to the Director until three days later. The CI described that resident #016 report to RPN #114 that their caregiver, PSW #115, had made rude comments towards them and made them wait a long time when they rang for assistance.

Inspector #612 and #543 interviewed RN #112 and #113 and PSW #117 and #118, who confirmed there was a zero tolerance of abuse within the home and that they were to immediately report any incidents of suspected abuse to their supervisors.

Inspector #612 reviewed the home's policy titled "Zero Tolerance of Abuse and Neglect-#COT-G10-v07", last revised February 15, 2016, which stated that all staff were responsible to report any witnessed, suspected, or alleged abuse to the appropriate supervisor or the Administrator at the time of the witnessed or alleged incident of abuse. If after hours, they were to call the supervisor on call.

Inspector #543 interviewed the DON, who confirmed that the incident was not immediately reported to the supervisor as per the home's policy. They confirmed that RPN #114 had only documented the incident but did not report it to a supervisor immediately. [s. 20. (1)]

2. Inspector #612 reviewed a CI, related to alleged verbal abuse from a visitor towards resident #015. The incident occurred during the evening shift on a specific date in March 2016, and the CI report was submitted the next day to the Director.

Inspector #612 interviewed RN #113 who confirmed that RPN #120 had reported the incident of verbal abuse from the visitor to resident #015 during the evening, however the visitor had left the building by the time the RN was made aware, therefore they did not report it. They stated that RPN #120 had charted the incident and that during report the next morning, management had reviewed the incident and then reported it to the Director. RN #113 confirmed it should have been reported immediately, during the evening shift.

Inspector #612 and #543 interviewed RN #112 and #113 and PSW #117 and #118, who confirmed there was a zero tolerance of abuse within the home and that they were to

immediately report any incidents of suspected abuse to their supervisors.

Inspector #612 interviewed the DON and the Nursing Care-Coordinator who confirmed they read about the incident the next day during report and therefore it was not immediately reported by RN #113 to the supervisor as per the home's policy. [s. 20. (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 the home's policy, "Zero Tolerance of Abuse and Neglect- #COT-G10-v07" last revised February 15, 2016, is complied with, to be implemented voluntarily.

Issued on this 1st day of June, 2016

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

Original report signed by the inspector.