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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

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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
Feb 3, 2021	2021_738753_0001	021139-20	Complaint

Licensee/Titulaire de permis

Golden Years Nursing Homes (Cambridge) Inc.
704 Eagle Street North P.O. Box 3277 Cambridge ON N3H 4T3

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

Golden Years Nursing Home
704 Eagle Street North P.O. Box 3277 Cambridge ON N3H 4T3

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

KATHERINE ADAMSKI (753)

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): January 6-7, 11-12, 2021

The following intake was completed during this Complaint Inspection:
Log #021139-20, related to continence care and an allegation of abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Continence Care Team Members, Residents, and Personal Support Workers (PSW).

The inspector also toured the home, observed resident care provision and completed record reviews.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Prevention of Abuse, Neglect and Retaliation

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure multiple residents had their participation in decision-making respected.

A complaint was reported to the Ministry of Long Term Care (MLTC) related to continence care products.

Documentation showed that multiple residents did not have their participation in decision-making respected when they were repeatedly provided with continence products not consistent with their preferences, which resulted in the resident's becoming extremely upset.

There was no documentation which showed that residents or their Substitute Decision Makers had consented to a product not consistent with their care plans.

Despite staff advocating for the residents to receive their preference for continence product, the DOC insisted that residents continue to trial the new product.

Sources: Interviews with staff, resident electronic records including progress notes, care plans, and kardex's, continence product assessment's, continence program binders. [s. 3. (1) 9.]

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 resident's have their participation in decision-making respected, 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 has failed to ensure that a residentwas protected from abuse by staff in the home.

Section 2 (1) of the Ontario Regulation 79/10 defines verbal abuse as 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 complaint was reported to the MLTC related to alleged verbal abuse between a resident and a staff member.

A staff member was heard talking over a resident and dismissing their concerns. The staff member then threw their arms up and took a piece of equipment that the resident required and made it inaccessible to them. After the incident, the resident was very upset and crying. The resident's mood remained low for several days.

The resident stated that during the interaction with the staff member, they were rude, did not listen to them and they felt disrespected. In addition, the encounter made them feel as though they had done something wrong. The resident also stated that the staff member's actions seemed aggressive.

There was actual emotional harm to the resident as a result of their interaction with the staff member.

Sources: Interviews with staff and the resident, complaint log #021139-20, written statements, the home's investigative notes. [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 resident #001 and any other resident is protected from abuse by 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. 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 failed to ensure that a person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

An allegation of abuse was reported to the Administrator and Assistant Director of Care.

A review conducted of the MLTC Critical Incident (CI) reporting system showed that a CI related to this allegation was not submitted to the Director as per the Long Term Care Home Act, 2007.

As a result of not reporting the incident to the Director, there was low risk of harm to the resident.

Sources: Interviews with staff, complaint log #021139-20, CI reporting system, written statements, the home's investigative notes. [s. 24. (1)]

Issued on this 9th day of February, 2021

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

Original report signed by the inspector.