**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**

**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**

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jul 14, 2014 | 2014_260521_0030 | 001492-14 | 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**

REBECCA DEWITTE (521)

## 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 08, 2014**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Nurse Manager, a Personal Support Worker and 2 Residents**

**During the course of the inspection, the inspector(s) conducted a tour of resident areas and common areas, observed residents and the care provided to them. Reviewed clinical records for identified resident. Reviewed policies and procedures.**

**The following Inspection Protocols were used during this inspection:**

**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**

**Findings of Non-Compliance were found during this inspection.**

| **NON-COMPLIANCE / NON - RESPECT DES EXIGENCES** | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Through interview it was determined a Resident is known to have behaviours.
A review of a Resident recent plan of care did not include interventions regarding behaviours to provide staff direction who give direct care to the resident.
The Nurse Manager indicated these interventions were part of a now discontinued care plan. The current care plan did not provide direction to staff.

This was confirmed by record review, Nurse Manager and the Director of Care. [s. 6. (1) (c)]

***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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.***

**WN #2: 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 immediately report the suspicion and the information upon which it is based to the Director of abuse of a resident by anyone that resulted in harm or a risk of harm to the resident.

A witnessed incident of alleged abuse occurred in a room of the home. The Administrator was notified immediately by the person that witnessed the incident. The Administrator failed to report to the Director.

The Administrator and the Director of Care confirmed the Director was not notified of the witnessed alleged abuse.

The Administrator confirmed it is the expectation that a person who has reasonable grounds to suspect abuse of a resident shall immediately report the suspicion to the Director. [s. 24. (1) 2.]

***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 a person who has reasonable grounds to suspect abuse of a resident shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents**

**Specifically failed to comply with the following:**

**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).**

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**Findings/Faits saillants :**

1. The licensee failed to ensure that the resident’s substitute decision-maker is notified within 12 hours upon becoming aware of an alleged, suspected or witnessed incident of abuse.

A witnessed incident of alleged abuse occurred to a Resident in a room in of the home.
The substitute decision-maker was not notified within 12 hours upon the licensee becoming aware of the incident of abuse.

The Administrator verified this and confirmed it is the expectation that the licensee notify the substitute decision-maker within 12 hours upon becoming aware of an alleged, suspected or witnessed incident of abuse. [s. 97. (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 the resident's substitute decision-maker are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse, to be implemented voluntarily.***

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**Issued on this 14th day of July, 2014**

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