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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 24, 2014	2014_325568_0009	L-000414-14	Critical Incident System

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF GREY
206 Toronto Street, MARKDALE, ON, N0C-1H0

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

GREY GABLES HOME FOR THE AGED
206 TORONTO STREET SOUTH, MARKDALE, ON, N0C-1H0

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

DOROTHY GINTHER (568)

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): June 27, 2014

During the course of the inspection, the inspector(s) spoke with an identified Resident, Registered Practical Nurse (RPN), 2 Personal Support Workers (PSW), the Director of Care, and the Administrator.

During the course of the inspection, the inspector(s) observed the identified Resident and staff interaction; reviewed the investigation notes, the home's policies pertaining to the inspection, and the identified Resident's health care 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 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. 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 the planned care for the resident.

Interview with a registered staff revealed that Resident #001 had their medication crushed and given in chocolate milk. The staff member indicated that this is the current practice for the administration of Resident #001's medication.

The Medication Administration Record (MAR) revealed that medication should be crushed and given in yogurt.

The Director of Care confirmed that staff take direction from the MAR in terms of how medication will be given. The MAR for Resident #001 did not reflect the current method for administration of medication. [s. 6. (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 there is a written plan of care for each resident that sets out the planned care for the resident, to be implemented voluntarily.

WN #2: 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 written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

Review of the Homes' Policy, Abuse or Suspected Abuse of a Resident V11-G-10.0 indicates that the procedure for a staff member that becomes aware of potential or actual abuse, be it by a staff member, volunteer, family member, or co-worker, is that they should immediately safeguard the resident and notify the Charge Nurse, who will in turn notify the DOC/Administrator.

Interview with a registered staff revealed that a Personal Support Worker reported that they had overheard another staff member yelling at a Resident in their room. When the registered staff went to the Residents' room, the Resident was found to be visibly upset and angry. [redacted] The registered staff reported being unsure of what to do as they had not personally heard or seen what had taken place.

Record review revealed that the registered staff member sent an email to the RAI Coordinator, who was not on duty in the home, outlining the incident and indicating that they were unsure of what to do. The registered staff did not report the incident to the Charge Nurse, Director of Care or the Administrator. A critical incident was not submitted to the Director until 2 days following the incident in 2014.

The Administrator confirmed that staff should follow the Home's policy for reporting incidents of alleged, suspected or witnessed abuse. [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 written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

Issued on this 28th day of July, 2014

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