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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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
Feb 28, 2014	2014_299559_0002	T-683-13	Complaint

Licensee/Titulaire de permis

IOOF SENIORS HOMES INC.
20 Brooks Street, BARRIE, ON, L4N-5L3

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

ODD FELLOW AND REBEKAH HOME
10 BROOKS STREET, BARRIE, ON, L4N-5L3

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

ANN HENDERSON (559)

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 20, 21, 22, 23, 2014.

During the course of the inspection, the inspector(s) spoke with Director of Resident Care (DRC), Assistant Director of Care (ADRC), Nurse Manager, registered nursing staff, health care aides, housekeeping staff and residents.

During the course of the inspection, the inspector(s) observed the provision of care to residents, reviewed clinical records, home policies related to abuse, educational training records and staff schedules.

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 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. 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 failed to protect resident #003 from physical and verbal abuse by anyone.

A health care aide revealed on an identified date he/she was providing care to resident #003 with another health care aide. She witnessed the other health care aide being verbally abusive to resident #003. The health care aide immediately reported this to the evening charge nurse. The evening charge nurse revealed that he/she emailed both the DRC and the ADRC at 2330h of the verbal abuse allegation. The ADRC indicated that on an identified date the home commenced an investigation of the above allegation, and the accused health care aide was called at home and advised not to return to work pending an investigation.
On the evening of an identified date, it was revealed by two health care aides that resident #003 reported to them that he/she had been hit on the back by a staff member. The health care aide then reported this to the RPN, who then reported this by email to the ADRC. The ADRC revealed that the above alleged verbal abuse was not immediately reported to the Director, however, it was reported the next day and the physical abuse was not reported.
Resident #003 revealed that he/she had been hit on the back by a staff member and indicated he/she had been spoken to roughly several weeks ago by a health care aide. Resident #003 indicated that he/she had reported the incident to staff at the home but was not further interviewed or assessed. Resident #003 indicated that the staff member who hit him/her no longer works on the home area.
Residents #002 and #004 revealed that the health care aide who was abusive to the resident is physically and verbally rough and resident #004 has requested that this health care aide does not provide his/her care anymore.
The health care aide confirmed that he/she did say the above and that he/she had physically tapped resident #003 on the back.
The DRC revealed the health care aide received a verbal warning and was required to read and sign the home's policy on Zero Tolerance for Abuse, Civil and Respectful Workplace and was relocated to another home area when he/she returned to work.
On an identified date, the DRC confirmed that the health care aide had not produced his/her signed policies but continues to work on the floor. Both the DRC and ADRC revealed in an interview that the family of resident #003 was notified of the verbal abuse but not of the physical abuse or of the outcome of the home's investigation. The DRC and ADRC revealed that the accused health care aide had not received prevention of abuse training in 2013. [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 protect residents from abuse by anyone , 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 ensure if a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred immediately reports it to the Director.

A health care aide revealed that on an identified date he/she was providing care to resident #003 with another health care aide. He/She witnessed his/her colleague being verbally abusive to resident #003. The health care aide immediately reported the above statements to the evening charge nurse. The evening charge nurse revealed that he/she emailed both the DRC and the ADRC of the above allegations. The ADRC indicated that on an identified date, the home commenced an investigation and the health care aide was called at home and advised not to return to work pending an investigation.
On an identified date it was revealed by two health care aides that resident #003 reported to them that he/she had been hit on his/her back by a staff member the evening before. The health care aide then reported this to the RPN, who then reported this by email to the ADRC. The ADRC revealed the alleged verbal abuse was not immediately reported to the Director, however, it was reported on the next day and the physical abuse was not reported. [s. 24. (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 a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

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).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's substitute decision-maker was notified within 12 hours upon becoming aware of any other alleged abuse.

A health care aide revealed that on an identified date, that when providing care to resident #003 with another health care aide, he/she witnessed the other staff member verbally abusing resident #003.
On an identified date resident #003 reported to both health care aides that were assigned to provide care he/she was hit on his/her back by a staff member the evening before.
The DRC and ADRC revealed that the family of resident #003 was informed of the verbal abuse but not of the physical abuse. [s. 97. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provide direct care to residents, receive training related to abuse recognition and prevention annually.

The DRC and ADRC revealed that the accused PSW had not received abuse recognition training in 2013. [s. 221. (2)]

Issued on this 28th day of February, 2014

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

Ann Henderson