Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jan 17, 19, 27, 2012	2012_099188_0004	Critical Incident

Licensee/Titulaire de permis

584482 ONTARIO INC
689 YONGE STREET, MIDLAND, ON, L4R-2E1

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

MANITOULIN LODGE
3 MAIN STREET, P. O. BOX 648, GORE BAY, ON, P0P-1H0

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

MELISSA CHISHOLM (188)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Nursing staff, Personal Support Workers and Residents.

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, observed staff to resident interactions, reviewed residents' health care records, reviewed policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. Inspector reviewed the home's policy titled "Abuse Policy" dated February 2005 on January 17, 2012. Inspector noted this policy does not contain an explanation of the duty under section 24 of the Act to make mandatory reports. Inspector noted the policy does not provide for a program that complies with the regulations, for preventing abuse and neglect of residents. The policy fails to include procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents. The licensee failed to ensure their policy to promote zero tolerance of abuse and neglect of residents includes the minimum requirements. [LTCHA 2007, S.O. 2007, c.8, s.20(2)]

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 subsections:

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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. Inspector reviewed a critical incident related to abuse. This incident was not immediately reported to the Director. The licensee failed to ensure any person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred was immediately reported the suspicion and the information upon which it is based to the Director. [LTCHA 2007, S.O. 2007, c.8, s.24(1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. Inspector reviewed the home's policy titled "Abuse Policy" dated February 2005 on January 17, 2012. Inspector noted this policy identifies "Provide information and education regarding abuse and the prevention of abuse". The policy fails to identify the training and retraining requirements for all staff including training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility and situations that may lead to abuse and neglect and how to avoid such situations. The licensee failed to ensure their written policy to promote zero tolerance of abuse and neglect of residents under section 20 of the Act includes the minimum requirements. [O.Reg. 79/10, s.96(e)]
2. Inspector reviewed the home's policy titled "Abuse Policy" dated February 2005 on January 17, 2012. Inspector noted this policy does not identify the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation. The licensee failed to ensure their written policy to promote zero tolerance of abuse and neglect of residents under section 20 of the Act includes the minimum requirements. [O.Reg. 79/10, s.96(d)]
3. Inspector reviewed the home's policy titled "Abuse Policy" dated February 2005 on January 17, 2012. Inspector noted this policy identifies "Provide information and education regarding abuse and the prevention of abuse" however fails to provide any further measures and strategies to prevent abuse and neglect. The licensee failed to ensure their written policy to promote zero tolerance of abuse and neglect of residents under section 20 of the Act includes the minimum requirements. [O.Reg. 79/10, s.96(c)]
4. Inspector reviewed the home's policy titled "Abuse Policy" dated February 2005 on January 17, 2012. Inspector noted this policy does not contain procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected. The licensee failed to ensure their written policy to promote zero tolerance of abuse and neglect of residents under section 20 of the Act includes the minimum requirements. [O.Reg. 79/10, s.96 (a)]
5. Inspector reviewed the home's policy titled "Abuse Policy" dated February 2005 on January 17, 2012. Inspector noted this policy does not contain procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents. The licensee failed to ensure their written policy to promote zero tolerance of abuse and neglect of residents under section 20 of the Act includes the minimum requirements [O.Reg. 79/10, s.96(b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. Inspector reviewed a critical incident related to abuse. This incident was not immediately reported to the police. The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incidents of abuse that the licensee suspects may constitute a criminal offence. [O.Reg. 79/10, s.98]

Issued on this 30th day of January, 2012

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