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

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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
Dec 15, 16, 2011	2011_049143_0049	Critical Incident

Licensee/Titulaire de permis

UNITED COUNTIES OF LEEDS AND GRENVILLE
746 County Road 42, P.O Box 100, ATHENS, ON, K0E-1B0

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

MAPLE VIEW LODGE
746 COUNTY ROAD, 42 EAST, P.O. BOX 100, ATHENS, ON, K0E-1B0

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

PAUL MILLER (143)

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 Nursing, the Assistant Director of Nursing and a resident.

During the course of the inspection, the inspector(s) Reviewed the residents health care record, observed staff and resident interactions, reviewed the homes abuse policy and mandatory reporting requirements and the homes internal abuse investigation report.

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

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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. A review of the homes Resident Abuse Policy MVL-RESPOL1 does not address the immediate notification of Ministry of Health, the resident/substitute decision-maker and or police. These additional matters sec. 20 (2) h, are provided for in Ontario Regulation 79/10 section 96, 97 and 98.

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 abuse policy address immediate notification and all regulatory requirements, to be implemented voluntarily.

WN #2: 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. A resident reported that a Personal Support Worker (PSW) had punched the resident in the head while on the toilet. The resident reported that the "PSW was angry with the resident for making loud sounds while being toileted and for taking so long". The homes internal investigation indicated that the resident had complained of pain from being hit. A Registered Nurse reported that the residents head was slightly reddened.
A Critical Incident Report (CIR) was submitted to the Ministry of Health.
A review of the CIR indicated that the appropriate police force was not immediately notified of the incident of abuse.

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 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. A resident reported that a Personal Support Worker (PSW) had punched the resident in the head while on the toilet. The resident reported that the "PSW was angry with the resident for making loud sounds while being toileted and for taking so long". The homes internal investigation indicated that the resident had complained of pain from being hit. A Registered Nurse reported that the residents head was slightly reddened.
The Director of Care left a voice message with the Ministry of Health and Long Term Care Duty Inspector Ottawa Service Area Office that a resident had been abused.
A review of the Critical Incident Report indicated that Director was not immediately notified of the incident of abuse.

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 Director is immediately notified of abuse of resident that resulted in harm or risk of harm, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following subsections:

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. A resident reported that a Personal Support Worker (PSW) had punched the resident in the head while on the toilet. The resident reported that the "PSW was angry at the resident for making loud sounds while being toileted and for taking so long". The homes internal investigation indicated that the resident had complained of pain from being hit. A Registered Nurse reported that the residents head was slightly reddened. The Critical Incident Report submitted to the Ministry of Health and Long Term Care indicated that the resident was appearing fearful of staff and that 2 staff at all times had been put in place to provide care.
A review of the CIS indicated that the residents Substitute Decision Maker (SDM) had not been immediately notified of the incident of abuse.

Issued on this 4th day of January, 2012

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