Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Sep 4, 2013	2013_214146_0042	H-000500-13, H-000541-13	Critical Incident System

Licensee/Titulaire de permis

MARYBAN HOLDINGS LTD
3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6

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

OAKWOOD PARK LODGE
6747 OAKWOOD DRIVE, NIAGARA FALLS, ON, L2E-6S5

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

BARBARA NAYKALYK-HUNT (146)

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): August 26, 27, 2013

This inspection was conducted for 2 Critical Incidents related to H-000500-13 and H-000541-13

During the course of the inspection, the inspector(s) spoke with the administrator, Director of Care (DOC), registered staff, Personal Support Workers (PSW's), recreation staff, residents and a family member.

During the course of the inspection, the inspector(s) reviewed the home's policy and procedure related to prevention of abuse, home's investigation notes, resident health records, contents of an employee file and observed a resident's room with a door alarm.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the following rights of residents were fully respected and promoted:
Every resident has the right to be protected from abuse.
(A)Resident #001 abused or sexually abused female residents in the home on five occasions since April 2013. In all cases, female residents were non-consenting. This information was confirmed by staff interviews, the health record and the DOC.
(B)Resident #002 reported that the resident saw a roommate, resident #003 being physically abused by a person. Resident #003, who was allegedly physically abused, was not interviewed by the home. When interviewed by the inspector, resident #003 indicated that he had been slapped. The home's investigation resulted in a conclusion that no abuse took place. However, resident #002 believes that the physical abuse occurred and is upset that the resident and three roommates are not protected from abuse because the identified person has continued to come into their room. The DOC confirmed that the identified person is still allowed on the unit where resident #002 resides. [s. 3. (1) 2.]

2. The licensee did not fully respect and promote the resident's right to be afforded privacy in treatment and caring for personal needs.
Resident #003 was provided with personal care with the privacy curtains open, enabling the roommates to view the procedure. This information was confirmed by the resident's roommate, the DOC and the documentation record of an interview with the identified staff person. [s. 3. (1) 8.]

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 following rights of residents are fully respected and promoted:
2. every resident has the right to be protected from abuse
8. every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs, 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 did not ensure that the written policy promoting zero tolerance of abuse was complied with.
On a date in August 2013, a registered staff member received a report from staff of sexual abuse, resident to resident. According to the home's policy on prevention of abuse CA-05-37-9, under the sub-title of Procedures, registered staff must contact the administrator or designate immediately for directions on how to proceed with the investigation of any alleged, suspected or witnessed abuse or neglect. The registered staff did not follow the policy. The DOC was notified of the sexual abuse two days later. This information was confirmed by the DOC. [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 there is a written policy in place to promote zero tolerance of abuse and neglect of residents, and to ensure that the policy is complied with, to be implemented voluntarily.

Issued on this 4th day of September, 2013

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

BARBARA NAYKALYK-HUNT.