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

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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
Dec 4, 2013	2013_246196_0010	S-000006-12, S-000007-12	Critical Incident System

Licensee/Titulaire de permis

KENORA DISTRICT HOME FOR THE AGED BOARD OF MANAGEMENT
35 Van Horne Avenue, Box 725, DRYDEN, ON, P8N-2Z4

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

PRINCESS COURT
PRINCESS STREET, BOX 725, DRYDEN, ON, P8N-2Z4

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

LAUREN TENHUNEN (196)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 14, 15, 16, 17, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOC), RAI Coordinator, Human Resources staff member, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents and family members

During the course of the inspection, the inspector(s) conducted a tour of all resident care areas, observed the provision of care and services to residents, observed the staff to resident interactions, reviewed the health care records for several residents, reviewed various home 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	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 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. In January 2013, the licensee submitted a Critical Incident report to the Director outlining an incident of staff to resident verbal abuse, which had occurred in December 2012. An interview was conducted in May 2013 with management staff members #103 and #104 and it was confirmed that the resident had reported the incident to management staff in December 2012 and that it was not reported to the Director until the home's investigation was complete and a letter of termination was given to the staff member in January 2013. The licensee did not report the incident of abuse to the Director immediately. [s. 24. (1)]

2. A letter of complaint was submitted to management staff member #102 in early 2013, outlining alleged abuse towards residents of the home. In May 2013, the inspector had a discussion with staff member #106 and management staff members #102 and #104. It was confirmed by the staff members that a written complaint had been received on a particular day in early 2013, and that it was then forwarded to the Licensee's Human Resources department the following day. Staff member #106 reported to the inspector that they had spoken with the complainant about concerns expressed in the letter, however according to management staff member #102, no investigation had been initiated and it was not reported to the Director.

The licensee failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur immediately reports the suspicion and the information upon which it is based to the Director: 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. [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 that ensures that a person who has reasonable grounds to suspect that any of the following has occurred or may occur immediately reports the suspicion and the information upon which it is based to the Director: 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, to be implemented voluntarily.

WN #2: 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. On May 14, 2013, staff member #105 provided the licensee's policy titled "Zero Tolerance of Abuse and /or Neglect" Draft ADM 450 with revision date of March 2012, to the inspector. It was reported that this policy is still in draft form, is to be used as a guideline and is for staff education/orientation and is not to be distributed in hard copy as per direction from administration via email. In addition, policy ADM 450 titled "abuse of a resident" with revision date of March 2007 was provided as the current "abuse policy" in effect at the home. These policies were reviewed for the required information and did not identify measures and strategies to prevent abuse and neglect. [s. 96. (c)]

2. On May 14, 2013, staff member #105 provided the licensee's policy titled "Zero Tolerance of Abuse and/or Neglect" Draft ADM 450 with revision date of March 2012, to the inspector. It was reported that this policy is still in draft form, is to be used as a guideline and is for staff education/orientation and is not to be distributed in hard copy as per direction from administration via email. In addition, policy ADM 450 titled "Abuse of a Resident" with revision date of March 2007 was provided as the current "abuse policy" in effect at the home. These policies were reviewed for the required information and did not 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 for resident care, and situations that may lead to abuse and neglect and how to avoid such situations.

The licensee failed to ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, (c) identifies measures and strategies to prevent abuse and neglect; (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. [s. 96. (e)]

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 that ensures that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, identifies measures and strategies to prevent abuse and neglect; identifies 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 for resident care, and situations that may lead to abuse and neglect and how to avoid such situations, to be implemented voluntarily.

WN #3: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The "risk of injury from falls" care plan for resident #001, as found in the care plan binder, with last update of May 10, 2013, included the intervention of "provide appropriate ambulation aids - currently in w/c". An interview was conducted with staff member #100 on May 14, 2013 and it was reported that this is no longer current and that this resident now requires a one person assist with a walker and uses a wheelchair when weak. The care plan had not been reviewed and revised to reflect resident #001's change in care needs.

The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary. [s. 6. (10) (b)]

2. The care plan for resident #005, as found in the care plan binder, with a print date of April 21, 2013 was reviewed. Under the focus of "resident safety" it included the intervention of "resident to have w/c seat alarm". Under the focus of "risk of injury from falls" with a print date of April 21, 2013, it included the intervention of "ensure (resident #005) is utilizing walker". An interview was conducted on May 15, 2013 with staff member #101 and it was reported that resident #005 no longer uses a walker and that the chair alarm is also not used any longer as there is a restraint in use. Staff member #101 confirmed that the care plan as found in the care plan binder had not been updated to reflect the current care needs of the resident.

The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary [s. 6. (10) (b)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. A letter of complaint, dated a particular day in 2013, was submitted to management staff #102 outlining alleged abuse towards residents in the home. In May 2013, the inspector had a discussion with staff member #106, and management staff members #102 and #104. It was confirmed by the staff members that a written complaint was received in early 2013, and that it was then forwarded to the Licensee's Human Resources department the following day. Staff member #106 reported to the inspector that they had spoken with the complainant about concerns expressed in the letter, however according to management staff member #102, no investigation had been initiated and it was not reported to the Director. A complaint was made alleging abuse towards residents in the home and it was not investigated by the licensee.

The licensee failed to ensure that, (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone. [s. 23. (1) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. In January 2013, the licensee submitted a Critical Incident to the Director outlining an incident of staff to resident verbal abuse which had occurred in December 2012. The submitted report did not include the name of the staff member that was alleged to have verbally abused the resident. The CI report was reviewed by management staff member #103 and #104 and it was confirmed that the staff member was not identified by name in the report.

The licensee failed to ensure that, in making a report to the Director under subsection 23 (2) of the Act, the licensee included the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: 2. A description of the individuals involved in the incident, including, i. names of all residents involved in the incident, ii. names of any staff members or other persons who were present at or discovered the incident, and iii. names of staff members who responded or are responding to the incident. [s. 104. (1) 2.]

Issued on this 4th day of December, 2013

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

Lauren Lenhuren #196.