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

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
Mar 24, 2014	2014_289550_0008	O-000162-14	Critical Incident System

Licensee/Titulaire de permis

peopleCare Not-For-Profit Inc
2 OVERLEA BLVD., TORONTO, ON, M4H-1P4

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

THE SALVATION ARMY OTTAWA GRACE MANOR
1156 WELLINGTON STREET, OTTAWA, ON, K1Y-2Z3

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

JOANNE HENRIE (550)

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): March 5 and 6 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, a Registered staff, a Family member, several Residents, several Personal Support Workers and a Dietary attendant.

During the course of the inspection, the inspector(s) reviewed 2 CI reports (#2873-000001-14, and #2873-000002-14), observed resident care and services, reviewed 4 resident's health care records, reviewed the Home's Zero Tolerance of Abuse and Neglect policy # A11 and two internal investigation reports.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. (4) in that all staff have receive retraining annually relating to the following:

* The Residents' Bill of Rights
* The home's policy to promote zero tolerance of abuse and neglect of residents
* The duty to make mandatory reports under section 24
* The whistle-blowing protections

During an interview on March 06, 2014 staffs #101, #102, and #103 told Inspector #550 they have not received training on the Home's Zero Tolerance of Abuse and Neglect policy in the last year.

Reviewing the education in-service attendance sign in sheets on abuse, Inspector # 550 noticed that 38 out of 182 employees received training on abuse in 2013.

The Home's policy # A11 Zero Tolerance of Abuse and Neglect revised February 2014 page 6 indicates under "Education and Training about Prevention of Abuse and Neglect Staff Education" that the Resident's Bill of Rights and the Policy on Zero Tolerance of Abuse and Neglect will be reviewed with each new employee during orientation and annually thereafter. [s. 76. (4)]

WN #2: 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 comply with O. Reg. 79/10, s. 97. (1) (b) in that the Resident's substitute decision maker was not notified within 12 hours upon becoming aware of an incident of abuse of a resident.

On a specified date in February 2014 at a specified time there was an incident of alleged sexual abuse by Resident #1 on Resident #4. The resident's substitute decision maker was made aware of the incident by the evening RPN at suppertime on a specified date in February 2014 during a visit to the Home; more than 12 hours after becoming aware of the incident.

The DONPC indicates in the Home's internal investigation report that "Staff #100 did not inform family". [s. 97. (1) (b)]

Issued on this 24th day of March, 2014

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

Joanne Henrie