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
Sep 13, 2013	2013_140158_0026	S-000362-13	Other

Licensee/Titulaire de permis

SMOOTH ROCK FALLS HOSPITAL
107 KELLY ROAD, P.O. BOX 219, SMOOTH ROCK FALLS, ON, P0L-2B0

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

SMOOTH ROCK FALLS HOSPITAL
107 KELLY ROAD, P.O. BOX 219, SMOOTH ROCK FALLS, ON, P0L-2B0

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

KELLY-JEAN SCHIENBEIN (158)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): September 5, 2013

During the course of the inspection, the inspector(s) spoke with the Long Term Care Unit Manager, Registered staff, residents and visitors.

During the course of the inspection, the inspector(s) conducted a tour of the home , reviewed resident health care records, reviewed Resident Council minutes, reviewed the home's "Abuse Prevention" policy and observed staff providing care to residents.

The following Inspection Protocols were used during this inspection:
Dining Observation

Prevention of Abuse, Neglect and Retaliation

Residents' Council

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. On September 5, 2013, staff # S-100 told the Inspector that resident # 01, who is aware of their actions, was sexually abusive towards cognitively impaired female residents.
The Inspector reviewed resident # 01 progress notes, which identified that resident # 01 was caressing resident # 03 bare legs in June and July 2013, was fondling resident # 04 breasts in July 2013 and was fondling resident # 02 genital area in August 2013.
Staff # 100 told the Inspector that in August 2013, the physician ordered a medication to manage resident # 01 increased libido and that in September 2013, the police were in to discuss with resident # 01, the consequences of their actions. Although the licensee took the above actions, it was only after there had been repeated incidents involving several female residents who had been sexually abused.
Staff # S-101 and S-102 were aware of resident # 01 sexual abusive behaviour and identified strategies taken to deter this behaviour, however, resident # 01 plan of care failed to identify the sexual abuse toward cognitively impaired female residents or interventions to protect them from this behaviour.
In August 2013, the home's internal incident report was completed regarding the witnessed sexual abuse of resident # 02, however, none of the sexual abuse incidents, including the August 2013 incident, were reported to the Director.
The licensee did not ensure that female residents were protected from abuse by resident # 01. [s. 19. (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 ensuring that all residents, particularly cognitively impaired female residents, are protected from abuse by resident # 01, to be implemented voluntarily.

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:

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. On September 5, 2013, staff # S-100 told the Inspector that resident # 01, who is aware of their actions, was sexually abusive towards cognitively impaired female residents.
The Inspector reviewed resident # 01 progress notes, which identified that resident # 01 was caressing resident # 03 bare legs in June and July 2013, was fondling resident # 04 breasts in July 2013 and was fondling resident # 02 genital area in August 2013.
The licensee failed to immediately report five incidents of sexual abuse to the Director. [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 ensuring that the home immediately reports incidents of alleged, suspected or witnessed incidents of abuse by anyone, to the Director, to be implemented voluntarily.

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. The licensee did not ensure that its written policy to promote zero tolerance of abuse and neglect of residents contained procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected; identified measures and strategies to prevent abuse and neglect and identified the 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. [s. 96.]

Issued on this 13th day of September, 2013

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