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

Division de la responsabilisation et de la performance du système de santé
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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
Jun 8, 11, 12, Jul 13, 2012	2012_027192_0030	Critical Incident

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6

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

ORCHARD TERRACE CARE CENTRE
199 GLOVER ROAD, STONEY CREEK, ON, L8E-5J2

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

DEBORA SAVILLE (192)

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, Director of Nursing, Registered Nurses, and residents related to H-000830-12.

During the course of the inspection, the inspector(s) reviewed medical records, incident reports, and policy and procedure.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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. 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 person who had reasonable grounds to suspect that abuse of a resident by anyone, that resulted in harm or risk of harm had occurred or may occur, failed to immediately report the suspicion and the information upon which it was based to the Director.

a) In 2012 resident 002 who is cognitively impaired and had not provided consent, was observed by a staff member having being touched inappropriately by a co-resident. No report was made to the Director.

b) In 2012 resident 002, who is cognitively impaired and had not provided consent, was observed by a staff member being touched inappropriately. No report to the Director was made for five days.

c) In 2012 resident 002 who is cognitively impaired and had not provided consent was observed by staff being touched inappropriately by a resident. No report was made to the Director.

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 a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff, that resulted in harm or risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

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 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. The licensee failed to ensure that the resident's substitute decision maker (SDM) and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. [r. 97. (1) (b)]

Resident 002, who is cognitively impaired and had not provided consent, was observed by staff on three occasions in 2012 being touched inappropriately by co-residents of the home.

Resident 002's SDM was notified in 2012, 6 days after the first observed incident of touching directed at resident 002. There is no documented notification of resident 002's SDM following one of the incidents of inappropriate touching without consent.

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 resident's substitute decision maker (SDM) and any other person specified by the resident are notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following subsections:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure the plan of care was based on, at a minimum, interdisciplinary assessment of safety risks with respect to the resident. [r. 26. (3) 19]

Resident 002 is documented to have been found in an unsafe condition in 2012. Documentation review and interview confirm that no assessment of the resident was completed to establish the potential of further risk associated with equipment in use. The equipment was removed from the resident in 2012 after the resident had damaged the equipment.

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 the plan of care is based on, at a minimum, interdisciplinary assessment of safety risks with respect to the resident, to be implemented voluntarily.

WN #4: 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. (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 failed to 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. [s. 20. (1)]

The home's policy on Abuse and Neglect, index I.D.: P-10, Section B indicates:
1. On becoming aware of abuse or neglect, suspected abuse or neglect, the person first having knowledge of this shall immediately inform the Administrator, or if not available, the Director of Nursing or Delegate.

In 2012 resident 002, who is cognitively impaired and had not provided consent, was noted to be touched inappropriately by a resident. Staff noting the incident did not report the incident to the Administrator, Director of Nursing or Delegate.

2. Annually, all staff receives education on the promotion and protection of the Resident's Bill of Rights, abuse prevention and the Resident Abuse policy.

Staff training records for the home indicate that to date in 2012 only 24% of staff have participated in training related to abuse. Training records for 2011 indicate that only approximately 60% of the staff received training related to resident abuse.

7. The Administrator or Director of Nursing must inform the substitute decision maker, or other person(s) of significance to the resident of the incident and immediate action(s) taken. The Administrator or Director of Nursing must notify Ministry of Health, Long Term Care Branch, and the Director of Operations. Section 24(1) of the LTCHA, requires that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk to the resident shall immediately report the suspicion and information on which it is based to the Director.

Resident 002, who is cognitively impaired and had not provided consent, was touched inappropriately by co-residents on three occasions. The substitute decision maker for resident 002 was not notified of the first two incidents for 6 days and was not notified of the third incident.

A report to the Director was submitted related to two of the incidents on a specified date in 2012, 5 days following the second incident. The third incident in 2012 was not reported to the Director.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training
Specifically failed to comply with the following subsections:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that staff receive training in the area of mandatory reporting under section 24 of the Act, of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to a resident, prior to performing their responsibilities.

a) Education records reviewed indicate that 25% staff have participated in training related to abuse in 2012 and that only approximately 60% of staff received training on the prevention of abuse and mandatory reporting in 2011.

b) Three of three staff interviewed indicated they were not aware of the mandatory reporting requirement under section 24 of the Act related to improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to a resident.

c) Three incidents of sexual touching involving a cognitively impaired resident who had not provided consent, were not immediately reported to the Director.

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 staff receive training in the area of mandatory reporting under section 24 of the Act, of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to a resident, prior to performing their responsibilities, to be implemented voluntarily.

WN #6: 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 subsections:

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;
(b) appropriate action is taken in response to every such incident; and
(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. The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, that the licensee knows of, or that is reported is immediately investigated.

a) Resident 002, who is cognitively impaired and had not provided consent, was observed being touched inappropriately by resident 001 in 2012. No investigation was initiated until after a second incident of inappropriate touching by resident 001 toward resident 002 was reported in 2012.

b) Resident 002, who is cognitively impaired and had not provided consent, was observed by staff being touched inappropriately in 2012. No investigation was initiated. The home was unable to identify the resident responsible for touching resident 001 at the time of this inspection.

Issued on this 16th day of August, 2012

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
(192)