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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 11, 2015	2015_365194_0013	O-000784-14	Critical Incident System

Licensee/Titulaire de permis

Glen Hill Terrace Christian Homes Inc.
200 Glen Hill Drive South WHITBY ON L1N 9W2

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

STRATHAVEN LIFECARE CENTRE
264 King Street East Bowmanville ON L1C 1P9

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

CHANTAL LAFRENIERE (194), KARYN WOOD (601), MARIA FRANCIS-ALLEN (552), SAMI JAROUR (570)

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): April 20, 21,22,23,24,27,28,29,30 May 04,05 and 06, 2015

The following Logs were concurrently inspected;Log #O-001102-14,# O-000847-14,# O-000784-14,# O-000851-14,# O-000884-14,# O-000885-14 ,# O-000678-14,# O-000741-14,# O-001689-15,# O-000749-14,# O-001769-14,# O-000687-14,# O-000663-14,# O-001047-14,# O-001008-14, # O-000679-14,# O-000745-14,# O-000878-14,# O-001044-14.

PLEASE NOTE: A Written Notification and Compliance Order under s. 6(7) identified in this report (Log#O-000745-14,#O-001689-15,#O-000749-14 and #O-000847-14) will be issued under a Complaint Inspection #2015_365194_0012 Log #O-001655-15,#000881-14 concurrently inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Administrator, Director of Care (DOC), Assistant Director of Care (ADOC),Nurse Educator,Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), RAI Coordinator, Receptionist, Dietitian, Chef, Physio Therapist(PT), Food Service Supervisor(FSS), Environmental Service Manager (ESM),Maintenance staff and Housekeeping staff.

Also completed during the inspection; review of identified resident's clinical health records, Critical Incident Reports, Internal investigation of abuse and falls, Licensee's Policy for Abuse, Preventions of Falls, Wandering. Observation of the Kitchen area, meal services and staff to resident provision of care.

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

During the course of this inspection, Non-Compliances were issued.

5 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of the incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident was taken to hospital.

Related to Log # O-000678-14

A critical incident report was received on an identified date for Resident #01. The CIR indicated, four days previously Resident #01 fell. Later that night, the resident complained of pain and was transferred to hospital.

Review of clinical records for Resident #01 indicated resident returned from hospital with an injury. The Director was not notified of the incident until two business days after the resident's return to the home.

The DOC confirmed that the director was not notified of the incident within one business day.(570) [s. 107. (3)]

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 be ensuring that the Director is informed no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to hospital., 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 has failed to ensure that the written policy "V-B-30.00 "Abuse and Neglect or a Resident - Actual or Suspected" is complied with.

Policy directs:
-The Administrator, DOC or designate if available, will notify the following individuals;
Resident's Family/POA

On an identified date the DOC received three letters from three staff members alleging neglect of care to three residents by staff. A Critical Incident Report was submitted describing concerns related to resident care.

DOC indicated that the SDM's for the residents were not informed of the allegations of neglect as directed by the licensee's policy. [s. 20. (1)]

WN #3: 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. The licensee has failed to ensure the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Definitions:
2(1)"Physical abuse" means the use of physical force by anyone other than a resident that causes physical injury or pain
(c) the use of physical force by a resident that causes physical injury to another resident
5) Neglect: defined
"Neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, an includes inaction or a pattern of inaction that jeopardizes the health, safety or well being of one or more residents

Log# O-001047-14

A Critical Incident Report for an incident of staff to resident physical abuse that occurred on an identified date was submitted to the Director seven days later.

The Critical Incident Report indicated that several staff reported a staff member being physically abusive during care.

During an interview, the Director of Care indicated that the Director was not notified immediately. The CIR was submitted seven days following the incident.(601)

Log# O-000663-14

A Critical Incident Report for an incident of resident to resident physical abuse, with injury, that occurred on an identified date was submitted to the Director two days later.

The action line was notified of the incident on two days after the incident.

During an interview, the Director of Care indicated that the Director was not notified immediately. The CIR was submitted two days following the incident.(601)

Log# O-000885-14

A Critical Incident Report for an incident of staff to resident verbal abuse that occurred on an identified date was submitted to the Director fifteen hours later.

On an identified date Resident #31 reported to the RPN #103 that PSW #142, was verbally abusive.

During an interview, the Director of Care indicated that the Director was not notified immediately. The CIR was submitted approximately fifteen hours following the incident. (601)

Log# O-000884-14

A Critical Incident Report for an incident of staff to resident emotional abuse that occurred on an identified date was submitted to the Director fourteen hours later.

On an identified date a resident reported to the charge nurse that PSW #142 had been emotionally abusive.

During an interview, the Director of Care indicated that the Director was not notified immediately. The CIR was submitted approximately fourteen hours following the incident. (601)

Log# O-000847-14

Critical Incident Report describes, on an identified date Resident #16 informed RPN# 155, that the resident rang the call bell to tell staff that care was required. Resident #16 was informed by staff that the next shift would be providing care.

During an interview the DOC indicated that the Director was not immediately notified of the incident of Resident neglect. Critical Incident Report was submitted eighteen hours after the resident had reported the incident.(194)

No further compliance actions will be required at this time. All inspected incidents occurred prior to compliance date of November 28, 2014 of exiting Compliance order issued to the Licensee under s.19(1) report #2014_293554_0028.

Further more concurrent to this inspection, incidents of abuse have been inspected that occurred after compliance date of November 28, 2014. The compliance order under

s.19(1)will be re-issued under report #2015_365194_0011. [s. 24. (1)]

WN #4: 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 has failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse of neglect to the resident.

DOC indicated that the SDM's for the resident's involved in the complaints received were not notified of the allegations of neglect. [s. 97. (1) (b)]

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. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident
(1) names of all residents involved in the incident

On an identified date a Critical Incident report was submitted to the Director for allegations of staff to resident neglect involving 5 residents at the home. The critical incident identifies the residents as # 1-5. During the inspection, the home was not able to identify the residents indicated in the critical incident. [s. 104. (1) 2.]

Issued on this 29th day of May, 2015

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

Original report signed by the inspector.