Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

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☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
November 5,6 & 7, 2012	2012_021111_0032	Critical Incident System

Licensee/Titulaire
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(s)
Lynda Brown (#111)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct 3 Critical Incidents inspections for log 000958, 000130 & 002842.

During the course of the inspection, the inspector spoke with: the Administrator & the Director of Care (DOC).

During the course of the inspection, the inspector: reviewed four employees files, reviewed the homes policies related to Falls Prevention & Prevention of Abuse, and reviewed the health records of 2 deceased residents.

The following Inspection Protocols were used in part or in whole during this inspection: Critical Incident response, Dignity, Choice and Privacy, Falls Prevention, Prevention of Abuse, Neglect and Retaliation.

☒ Findings of Non-Compliance were found during this inspection.
The following action was taken:

6 WN
5 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with O.Reg. 79/10, s.8. Policies, etc., to be followed, and records
Specifically failed to comply with the following:
s.8(1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(b) Is complied with.

Findings:
1) Related to log 000130:

Under O.Reg. 79/10, s. 114(2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destructions and disposal of all drugs used in the home.

Review of the homes policy "narcotics & Controlled Drugs" (11-20) (dated Sept. 2010) indicated that two staff (one leaving and one coming on duty) must complete a narcotic count at the end/beginning of each shift. Any discrepancy in the narcotics will be reported to the Director of Care immediately. All missing narcotics will be reported in compliance with local and regional legislation, professional regulatory bodies and practice law/regulations.

Critical Incident (CI) (2605-000001-12) was received for a missing narcotics incident that occurred. The home completed an internal investigation and determined that the staff involved in the incident was not following the homes policy.

The licensee failed to ensure that the policy of "Narcotics & Controlled Drugs"' was complied with [s.8 (10)(b)].

2) Related to log 000958:

Under the LTCHA, 2007, s. 20(2)(e) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents, shall contain procedures for investigation and responding to alleged, suspected or witnessed abuse and neglect of residents.

Review of the home s policy "Resident Abuse and Neglect" (OPER-02-02-04) (dated July 2012) indicated all reported incidents of abuse and neglect will be objectively, thoroughly, promptly, and accurately investigated. The Administrator/DOC/designate will initiate an internal investigation and complete a preliminary report before going off duty. Ensure comprehensiveness of all investigative documentation. Document pertinent details of the investigation, actions taken during the investigation and any actions taken as a result of the

outcome of the investigation.

A CI (2605-000007-12) was received for a staff to resident emotional abuse incident that occurred towards an identified cognitively impaired.

Interview of the DOC indicated that the home completed an investigation into the incident of staff to resident emotional abuse but there was no documented evidence of an investigation.

The licensee failed to ensure that the policy of "resident Abuse & Neglect" was complied with [s.8 (1)(b)].

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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 to ensure that the homes Narcotics & Controlled Substances, as well as the Resident Abuse & Neglect policy is complied with, 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:
2. 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.

Findings:
Related to log 000958:

A CI (2605-000007-12) was received for a staff to resident emotional abuse incident that occurred resulting in a risk of harm to an identified cognitively impaired resident and was not immediately reported.

Interview of the DOC confirmed that the incident was not reported for a period of five days after the incident occurred.

The licensee failed to ensure that when a person had reasonable grounds to suspect that abuse of a resident occurred by a staff member that resulted in risk of harm to the resident was reported immediately to the Director [s.24 (1)2].

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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 to ensure that when a person has reasonable grounds to suspect that abuse of a resident has occurred by anyone that results in harm or risk of harm to a resident is reported immediately to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg. 79/10, s.36. Every Licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Findings:
Related to log 002842:
A CI (2605-000031-11) was received for a resident who sustained an injury resulting in transfer to hospital incident that occurred resulting in injury.

Interview of the DOC confirmed that the staff failed to use safe positioning devices when assisting the identified resident.

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents [s.36].

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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 to ensure that all staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: 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(2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

Findings:
Related to log 000958:

Under the O.Reg. 79/10, s.2(1) For the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "emotional abuse" means,

(a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgment or infantilization that are performed by anyone other than a resident,

A CI (2605-000007-12) was received for a staff to resident emotional abuse incident that occurred resulting in a risk of harm to the identified resident. The report was submitted to the Director greater than tens days after the incident occurred.

The licensee failed to make a report to the Director within 10 days for an incident of staff to resident emotional abuse that occurred resulting in risk of harm to the resident [s.104(2)].

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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 to ensure that the licensee makes the report to the Director within 10 days of becoming aware of any alleged, suspected or witnessed incident of abuse of a resident by anyone, to be implemented voluntarily.

WN #5: 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):
3. A missing or unaccounted for controlled substance

Findings:

Related to log 000130:

A (CI) (2605-000001-12) was received for a missing narcotics incident that occurred and the Director was not notified for a period of 7 days.

Interview of the DOC confirmed that the Director was not notified until the CI was submitted 7 days later.

The licensee failed to ensure that when an incident of misappropriation of narcotics occurred, that the Director was notified within one business day after the occurrence of the incident [s.107 (3)3].

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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 to ensure that any incidents of missing or unaccounted for controlled substances are reported to the Director within one business day, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg. 79/10, s.98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Findings:

Related to log 000958:

Under the O.Reg. 79/10, s.2(1) For the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "emotional abuse" means,

(b) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgment or infantilization that are performed by anyone other than a resident,

A CI (2605-000007-12) was received for a staff to resident emotional abuse incident that occurred resulting in risk of harm to the identified resident. The CI indicated that police were notified.

Interview of the Doc confirmed that the police were not notified of the witnessed incident of staff to resident emotional abuse.

The licensee failed to ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence [s.98].

Inspector ID #:	111

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:** Dec. 20/12	**Date of Report:** (if different from date(s) of inspection).