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

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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
Oct 17, 18, 19, 23, 24, 2012	2012_049143_0039	Critical Incident

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9

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

STREAMWAY VILLA
19 JAMES STREET WEST, COBOURG, ON, K9A-2J8

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

PAUL MILLER (143)

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, a Registered Nurse, Registered Practical Nurse's, a Personal Support Worker, residents' and a family member.

During the course of the inspection, the inspector(s) completed two Critical Incident inspections log # O-000466-12 and O-000483-12.

The Inspector reviewed the home's Abuse Policy and Procedure, internal abuse investigation reports and disciplinary investigations. Copies of a resident health care record was obtained and reviewed.

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The following findings are in respect of log # O-000483-12:

On February 25th, 2012 at approximately 1345 hours a resident # 1 with cognitive impairment was demonstrating physical and aggressive behavior towards a Registered Nurse, staff member S105. A Personal Support Worker (PSW) S101 reported that they observed resident #1 kick S105(RN) twice in the leg. Staff member S101(PSW) reported and documented that S105(RN) kicked the resident back on the resident right shin. S101 (PSW) in their witness statement dated February 27, 2012 documented that they had taken resident # 1 for a bath and noticed a small abrasion on the residents right shin and that the resident had complained that it was sore. S101(PSW) documented that they reported this injury to the S105(RN) who made a joking comment, "yeah, well". A Registered Practical Nurse (S103) was made aware of the incident on or about 1500 hour on February 25, 2012. S101(PSW) was advised to complete a written statement and that the incident needed to be reported. S103(RPN) notified the on call manager at approximately 1815 hours. S105(RN) was informed by the Administrator on February 25th, 2012 that they were suspended until the incident could be further investigated.
A family member reported the incident to the Administrator on February 27, 2012. The family member completed a witness report. The witness statement reported that resident # 1 kicked S105(RN) twice. The family member reported that S105(RN) then kicked the resident back stating to the the resident see that hurts. The family member was interviewed by telephone on October 18th, 2012. The family member reported that they were standing in the hallway approximately five to ten feet away and was able to see the incident with no obstruction. The family member reported that the resident # 1 was very aggressive and that S101 (PSW) was standing behind the resident with a full view of the altercation. The family member was very descriptive of the incident. Family member reported being concerned for their spouse safety and not knowing whom to trust as the abuser at the time of the incident was the Charge Nurse responsible for the entire home on the weekend.
On October 17th, 2012 the Administrator reported to the inspector that S105(RN) had a knee jerk reaction to being kicked by the resident. The Administrator confirmed that this reaction occurred following the second kick and not after the first kick. The Administrator reported that resident # 1 had a hold of the S105(RN) arms and had the staff member cornered against the wall without an exist opportunity. The Administrator reported that her investigation did not confirm that S105(RN) had physically abused the resident as Ontario Regulation 79/10 section 2 (2) physical abuse does not include the use of force that is appropriate to the provision of care. Discussions held as per O.Reg70/10 section 2(2) "unless the force used is excessive in the circumstances." The Administrator provided a Disciplinary report dated February 28, 2012 that indicated that S105(RN) received a suspension pending abuse investigation and received a written warning for failing to follow the polices in caring for a physically aggressive/abusive resident (Policy # TO-11.5).
On October 17th, 2012 the S101(PSW) was interviewed. The PSW was provided an opportunity to review the documentation of their statement. The PSW reported to the inspector that resident #1 kicked the staff twice and that the staff kicked resident #1 back. This staff member reported that they did not believe that the S105(RN) intentionally tried to hurt the resident and believe that S105(RN) response was more of a reaction. Questioned about the skin abrasion and reported that the resident did not have a tear on their right shin but had sustained a reddened mark and had complained that the area hurt. This staff member reported that they had reported the incident to a Registered Practical Nurse (S103)
On October 18th, 2012 the S105(RN) was interviewed. This staff member reported to the inspector that the resident was coming at them with arms flaying in the area and in an aggressive manner. The RN was questioned if they had their back against the wall and if the medication cart was blocking them in and reported no. S105(RN) reported their position as standing at the side of the medication cart. The S105(RN) was asked if the hallway to the left and right was open and free of obstruction and indicated yes. The RN was asked if the resident had grabbed them and indicated no. Reported that resident # 1 came and started kicking. Asked how many times the staff member was kicked and reported three to four times. The S105(RN) reported that in their attempt to get around the resident they tried to step over/around the resident had which time her foot struck the resident. The S105(RN) was questioned if they had assessed the resident for injury and documented the incident and indicated that they had. A review of the file indicated that the incident was documented in respect of resident # 1 having increased agitation and did become aggressive. S105(RN) did not complete a nursing assessment having knowledge that the resident had complained of pain and had sustained an injury.
On October 18th, 2012 at approximately 1500 a telephone interview was completed with S103 a Registered Practical Nurse. This staff member reported that they had not witnessed the incident. This RPN reported that S101(PSW) made them aware of the incident and they had informed S101 (PSW) to make a statement. S103(RPN) reported that the resident was not assessed for an injury.

A Ministry Nursing Inspector completed a complaint investigation dated January 6, 2012 that indicated that the licensee had not ensured that residents right to be treated with dignity and respected was complied with. On January 4, 2012 S107(PSW) reported that they had witnessed S105(RN) slapping a resident. The Administrator reported on October 17th, 2012 that S105(RN)had received a verbal warning in respect of the incident of January 4, 2012.
The licensee has failed to ensure that every resident has the right to be protected from abuse.

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 residents are not abused and staff are educated on zero tolerance abuse policy and procedure to ensure that residents are assessed, 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 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 following findings are in respect of log # O-000483-12:

The licensee's policy Zero Tolerance of Abuse and Neglect of Residents Policy # AM-6.9 pg 4 procedure 7 states
-Follow up care for the resident at issue as deemed appropriate by medical and nursing assessment

On February 25, 2012 between 1330 hours to 1500 hours Personal Support Worker (PSW) S101 reported to S105 (Registered Nurse(RN)) that resident # 1 had sustained an injury and was complaining of discomfort following being kicked in a physical altercation with S105(RN). A Registered Practical Nurse (RPN) S103 was made aware of the resident injury and complaint of discomfort on or about 1500 hours on February 25, 2012. On or about 1800 the Administrator was made aware of the allegations of abuse. S105(RN) documented on February 25, 2012 at 1437 increased agitation noted. Did become aggressive. A review of the nursing progress notes and assessment tools and internal abuse investigation reports did not indicate that a nursing assessment had been completed assessing resident # 1 injury and discomfort sustained in a physical altercation of February 25, 2012 with S105 (RN).

The Licensee has failed to comply with Section 20(1) by not ensuring that their abuse policy is complied with.

Issued on this 24th day of October, 2012

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