Ontario

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
Direction de l'amélioration de la performance et de la conformité

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Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 15, 17, Jul 19, 2011	2011_048175_0008	Complaint

Licensee/Titulaire de permis

DIVERSICARE CANADA MANAGEMENT SERVICES CO., INC
2121 ARGENTIA ROAD, SUITE 301, MISSISSAUGA, ON, L5N-2X4

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

PERTH COMMUNITY CARE CENTRE
101 CHRISTIE LAKE ROAD, R. R. #4, PERTH, ON, K7H-3C6

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

BRENDA THOMPSON (175)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care and Registered Nursing staff 2nd Floor Nursing Unit

During the course of the inspection, the inspector(s) reviewed home's Critical Incident Report #0962-000005-11, the Abuse Policies and Procedures, employee files, resident health record and observed care provided to residents on 2nd Floor Nursing Unit on the evening shift.

The following Inspection Protocols were used in part or in whole 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

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Definitions	Définitions
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. 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 sayants :

1. The Home's Resident Abuse Policy and Procedure # NM-II-R005 directs staff "when resident abuse or neglect is witnessed or suspected by a staff..., as a primary step, ensure that the resident is safe and receives necessary medical care/support, immediately seek out his/her immediate supervisor...in order to report the incident, once the resident is physically safe.
2.Two Personal Support Workers (PSW) witnessed the incident of abuse, of a resident, by their co-worker, and left the room.
3. One PSW reported the incident after the shift, to a mentor PSW, to ask what to do,related to the incident. This PSW was advised that the information had to be reported to the Director of Care. The PSW left the Home without reporting the incident to the Director of Care and/or other Supervisor.
4. The second PSW who witnessed the incident, did not report to the Director of Care and/ or any Supervisor before leaving the Home at the end of the shift.
5.Interview with Director of Care on June 16, 2011, stated that on the shift when the incident occurred, the Supervisor of the Home is
the Registered Nurse. Review of written statement from the Registered Nurse on the shift when the incident occurred, indicated no awareness of any incident.
6.Interview with the Director of Care on June 16, 2011, stated that " At no point did anyone follow up with the nurse to report the incident or make sure that an assessment of the resident was done."
7.Staff did not comply with the home's Resident Abuse Policy and Procedure # NM-II-R005.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 subsections:

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 sayants :

1. According to Critical Incident Report # 0962-000005-11,two Personal Support Workers, were working with another Personal Support Worker. All three Personal Support Workers were working together, to toilet a resident. The resident started kicking staff and spitting at them. Two of the Personal Support Workers then witnessed the third Personal Support Worker, who " took a pillow and covered the resident's face with it to stop the spitting and then stopped the resident from kicking by using undue force. This Personal Support Worker, then said loudly "I hate getting spit on, maybe I should rub a dirty brief in the resident's face and see how the resident feels".
2.According to an interview conducted with the Director of Care which indicated that the Personal Support Workers neglected to take any action to provide assistance to the resident or to summon help for the resident during the incident or to report the incident to the Registered Practical Nurse in charge the Nursing Unit or to the Registered Nurse/Supervisor. Following the shift, one Personal Support Workers discussed the details of the witnessed incident to another staff member, then left the Home. The second Personal Support Worker, did not report or discuss the witnessed incident with anyone before leaving the Home.
3.The licensee failed to protect residents from abuse by anyone and did not ensure that residents are not neglected by the licensee or staff.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care
Specifically failed to comply with the following subsections:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits sayants :

1.The resident's left ear was assessed by audiologist June 16, 2011, and found to be inflamed and the possibility of a piece of broken hearing aide lodge within the ear.
2. The resident's family member removed the broken hearing aide and took it home. No hearing aide was available to the resident.
3.Plan of care May 31, 2011, says hearing aid is available and used. Plan of care was not revised to reflect ear inflammation and the unavailability of the hearing aide.

Issued on this 26th day of July, 2011

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

B Thompson

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BRENDA THOMPSON (175)
Inspection No. / No de l'inspection :	2011_048175_0008
Type of Inspection / Genre d'inspection:	Complaint
Date of Inspection / Date de l'inspection :	Jun 15, 17, Jul 19, 2011
Licensee / Titulaire de permis :	DIVERSICARE CANADA MANAGEMENT SERVICES CO., INC 2121 ARGENTIA ROAD, SUITE 301, MISSISSAUGA, ON, L5N-2X4
LTC Home / Foyer de SLD :	PERTH COMMUNITY CARE CENTRE 101 CHRISTIE LAKE ROAD, R. R. #4, PERTH, ON, K7H-3C6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JOYCE FIRLOTTE

To DIVERSICARE CANADA MANAGEMENT SERVICES CO., INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that Resident Abuse Policy #NM-II-R005 and Abuse Prevention Program Policy #ADM -VIII-005 are complied with.

Grounds / Motifs :

1. The Home's Resident Abuse Policy and Procedure # NM-II-R005 directs staff "when resident abuse or neglect is witnessed or suspected by a staff..., as a primary step, ensure that the resident is safe and receives necessary medical care/support,
immediately seek out his/her immediate supervisor...in order to report the incident, once the resident is physically safe.
2.Two Personal Support Workers (PSW) witnessed an incident of resident abuse, by their co-worker, and left the room.
3. One PSW reporterd the incident, after the shift on, to a mentor PSW, to ask what to do related to the witnessed incident. The PSW was advised that the information had to be reported to the Director of Care. The PSW left the Home without reporting the incident to the Director of Care and/or other Supervisor.
3. The second PSW did not report the witnessed incident, to the Director of Care and/ or any Supervisor before leaving the Home at the end of the shift.
5.Interview with Director of Care on June 16, 2011, stated that on the shift the incident occurred, the Supervisor of the Home isthe Registered Nurse. Review of written statement from the Registered Nurse on the shift the incident occurred, indicated that she an unawareness of any incident.
6.Interview with the Director of Care on June 16, 2011, stated that " At no point did anyone follow up with the nurse to report the incident or make sure that an assessment of the resident was done."
7.Staff did not comply with the home's Resident Abuse Policy and Procedure # NM-II-R005.

(175)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 27, 2011

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that all residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. The plan is to be submitted to Inspector Brenda Thompson, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 347 Preston Street, 4th Floor, Ottawa ON K1S 3J4, Fax 613 -569-9670

Grounds / Motifs :

1. According to Critical Incident Report # 0962-000005-11, two Personal Support Workers,(PSW) were working with another Personal Support Worker. All three Personal Support Workers were working together, to toilet a resident.. The resident started kicking staff and spitting at them. The two PSW witnessed the third PSW, who " took a pillow and covered the resident's face with it to stop the spitting and then stopped the resident from kicking by using undue force. The third PSW then said loudly "I hate getting spit on, maybe I should rub a dirty brief in the resident's face and see how the resident feels".
2.According to an interview conducted with the Director of Care, the Personal Support Workers neglected to take any action to provide assistance to the resident or to summon help for the resident during the incident or to report the incident to the Registered Practical Nurse in charge of the Nursing Unit or to the Registered Nurse/Supervisor. Following the shift, one PSW discussed the details of the witnessed incident with another staff member, then left the Home. The second PSW did not report or discuss the witnessed incident with anyone before she left the Home.
3.The licensee failed to protect residents from abuse by anyone and did not ensure that residents are not neglected by the licensee or staff.
(175)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 28, 2011

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION / RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-760

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director

c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Clair Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Issued on this 20th day of July, 2011

Signature of Inspector / Signature de l'inspecteur : B Thompson

Name of Inspector / Nom de l'inspecteur : BRENDA THOMPSON

Service Area Office / Bureau régional de services : Ottawa Service Area Office