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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 23, 2014	2014_163109_0024	T-831-14	Complaint

Licensee/Titulaire de permis

TORONTO LONG-TERM CARE HOMES AND SERVICES
55 JOHN STREET, METRO HALL, 11th FLOOR, TORONTO, ON, M5V-3C6

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

TRUE DAVIDSON ACRES
200 DAWES ROAD, TORONTO, ON, M4C-5M8

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

SUSAN SQUIRES (109)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 8, 14, 2014.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), registered nursing staff, maintenance/custodian staff member, family member, resident, personal support workers (PSW), registered dietitan.

During the course of the inspection, the inspector(s) reviewed the health record for an identified resident, reviewed the home's policies for abuse prevention, reviewed the maintenance records observed the interactions between staff and an identified resident on the care unit, conducted a walk through of the unit.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(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 that the licensee knows of, or that is reported is immediately investigated.

On an identified date resident #1 reported to the substitute decision maker (SDM) that he/she had been physically abused by a staff member. When the SDM arrived at the unit, the resident alleged that the nurse had assaulted him/her. The resident was transferred to the hospital where hospital staff found bruising on the resident and alleged assault of resident #1 at the home.

Staff interview indicates that there was no investigation into the allegation against the staff member who had allegedly abused the resident.

According to the DOC, the nurse manager no longer works at the home and was unable to find any investigation notes for this allegation of abuse.

The inspector determined through family interview that the resident had mistaken the name of staff member accused of abusing him/her with the name of another staff member that does not work on the unit. The home did not investigate either of the staff members.

The accused staff member has continued to work on the same unit and provide care to the resident since the allegation was made and the resident has since made a further allegation of abuse by the same staff member. [s. 23. (1) (a)]

2. According to the critical incident submitted to the Ministry of Health the resident alleged physical abuse on an identified date. The critical incident further states that an investigation would be started immediately with the staff that were working with the resident on the identified date.

Interview with the DOC revealed the nurse manager for the unit deemed there was no need for an investigation to be completed because the physician stated that the abuse may not have occurred because of the resident's underlying health conditions. [s. 23. (1) (a)]

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 every alleged, suspected or witnessed incident of abuse of a resident that the licensee knows of, or that is reported is immediately investigated, to be implemented voluntarily.

WN #2: 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:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

The licensee failed to ensure that the report to the Director included the long-term actions planned to correct the situation and prevent recurrence.

Record review of the critical incident report related to an alleged abuse of a resident on an identified date, and interview with the Director of Care reveal that there was no long term actions outlined to correct the situation and prevent recurrence.

The critical incident states that it will be amended upon completion of the investigation. There were no amendments made to this critical incident report.

The administrator indicated to the inspector that the critical incident report would be updated. [s. 104. (1) 4.]

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 report to the Director included the long-term actions planned to correct the situation and prevent recurrence, to be implemented voluntarily.

Issued on this 28th day of July, 2014

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