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

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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
Jul 5, 7, 12, 2011	2011_054133_0006	Mandatory Reporting

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

LAKEHEAD MANOR
135 SOUTH VICKERS STREET, THUNDER BAY, ON, P7E-1J2

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Mandatory Reporting inspection.

During the course of the inspection, the inspector(s) spoke with the acting Administrator, the Director of Care, the office manager, one Registered Nurse, three Registered Practical Nurses, three Personal Support Workers, one housekeeping services staff person, one restorative care program staff person, one resident and that resident's visiting family member.

During the course of the inspection, the inspector(s) During the course of the inspection, the inspector: conducted a walk-through of all resident home areas and various common areas, observed residents, observed staff practices and interactions with the resident. The inspector reviewed the home's investigation notes related to the incident of alleged abuse that occurred on June 12, 2011, the home's "Resident Non Abuse" policy LP-B-20 with revision date April 2011, the licensee's "Resident Non-Abuse & S.T.O.P. Abuse Intervention" training program and home records related to abuse training and attendance.

The following Inspection Protocols were used in part or in whole during this inspection:

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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. 76. Training

Specifically failed to comply with the following subsections:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits sayants :

1. As it relates to s. 76(2)4: Training in the area of mandatory reporting under section 24 of the Act is delivered in the Revera Resident Non-Abuse S.T.O.P. Abuse Intervention training program. The office manager gave Long Term Care Home Inspector (LTCHI) #133 a copy of the active employee seniority list for Lakehead Manor. The Director of Care gave LTCHI #133 documentation related to the education received by staff at Lakehead Manor for 2010 and 2011. Information from these documents indicate that 8 staff members hired since July 1, 2010 did not complete the Revera Resident Non-Abuse S.T.O.P. Abuse Intervention training program.
2. .
As it relates to s. 76(2)3: Training on the home policy to promote zero tolerance of abuse and neglect of residents is delivered in the Revera Resident Non-Abuse S.T.O.P. Abuse Intervention training program. The office manager gave Long Term Care Home Inspector (LTCHI) #133 a copy of the active employee seniority list for Lakehead Manor. The Director of Care gave LTCHI #133 documentation related to the education received by staff at Lakehead Manor for 2010 and 2011. Information from these documents indicate that 8 staff members hired since July 1, 2010 did not complete the Revera Resident Non-Abuse S.T.O.P. Abuse Intervention training program.

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 with ensuring that no staff perform their responsibilities before receiving training in the area of the duty under section 24 to make mandatory reports and the long term care home's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following subsections:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights;
(b) the long-term care home's mission statement;
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
(d) an explanation of the duty under section 24 to make mandatory reports;
(e) the long-term care home's procedure for initiating complaints to the licensee;
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints;
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained;
(h) the name and telephone number of the licensee;
(i) an explanation of the measures to be taken in case of fire;
(j) an explanation of evacuation procedures;
(k) copies of the inspection reports from the past two years for the long-term care home;
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years;
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years;
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council;
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council;
(p) an explanation of the protections afforded under section 26; and
(q) any other information provided for in the regulations. 2007, c. 8, ss. 79 (3)

Findings/Faits sayants :

1. As it relates to s. 79(3)d: An explanation of the duty under section 24 to make mandatory reports is not posted in the home as required by LTCHA s. 79 (1) "Every licensee of a long term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following subsections:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits sayants :

1. The alleged abuse of a resident occurred during the night shift on June 12, 2011 and was reported to the home by the resident's daughter and substitute decision maker (SDM). The investigation into the alleged abuse was concluded on June 17, 2011. On July 5, 2011, Long Term Care Homes Inspector (LTCHI)#133 arrived at Lakehead Manor to conduct an inspection related to this matter. Only upon discussion with LTCHI #133 did the Director of Care contact the resident's daughter/SDM to notify her of the results of the investigation.
2. .
LTCHI #133 met with the same resident and that resident's daughter/SDM, while at Lakehead Manor on July 8, 2011. The daughter/SDM told LTCHI #133 that she had been contacted by Director of Care on July 5, 2011. She informed LTCHI #133 that she was told that the Personal Support Worker (PSW) involved in the incident of alleged abuse had been moved to a different floor. LTCHI #133 asked if she had been made aware that the investigation had concluded that the resident's rights had not been respected because the PSW made the statement "You are insistent on falling down". The resident's daughter/SDM stated that she had not been made aware of this.

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 with ensuring that a resident and that resident's substitute decision makers, if any, are notified of the results of any investigation into alleged, suspected or witnessed incident of abuse of that resident by anyone, immediately upon the completion of the investigation, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 225. Posting of information

Specifically failed to comply with the following subsections:

s. 225. (1) For the purposes of clause 79 (3) (q) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 79 of the Act includes the following:
1. The fundamental principle set out in section 1 of the Act.
2. The home's licence or approval, including any conditions or amendments, other than conditions that are imposed under the regulations or the conditions under subsection 101 (3) of the Act.
3. The most recent audited report provided for in clause 243 (1) (a).
4. The Ministry's toll-free telephone number for making complaints about homes and its hours of service.
5. Together with the explanation required under clause 79 (3) (d) of the Act, the name and contact information of the Director to whom a mandatory report shall be made under section 24 of the Act. O. Reg. 79/10, s. 225 (1).

Findings/Faits sayants :

1. As it relates to s. 225 (1)(5): The name and contact information of the Director to whom a mandatory report shall be made under section 24 of the Act has not been posted in the home as required by the LTCHA, 2007, S.O. 2007, C. 8. s.79 (1) "Every licensee of a long term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

WN #5: 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 sayants :

1. As it relates to s. 3(1)1: On June 13, 2011 a resident reported that they did not feel safe around a staff person who helps them to the bathroom during the night. An investigation was conducted by the Director of Care and a certain Personal Support Worker (PSW) was identified as the staff person that the resident does not feel safe with. The investigation concluded that the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity was not fully respected. This conclusion was made because the PSW reported that when they had entered the resident's bedroom during the night shift of June 12, 2011, they found the resident walking to their bathroom and said "You are insistent on falling down". The resident wears a Posey alarm attached to their clothing and to their bed which is intended to alert staff when the resident gets up so they can accompany the resident to the bathroom, in an effort to prevent the resident from falling.

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 with ensuring that all resident's 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 is fully respected and promoted, to be implemented voluntarily.

Issued on this 15th day of July, 2011

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