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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 18, 2016	2016_30610a_0004-A1	015712-15	Complaint

Licensee/Titulaire de permis

MIRDEM NURSING HOMES LTD
176 VICTORIA AVENUE NORTH HAMILTON ON L8L 5G1

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

VICTORIA GARDENS LONG TERM CARE
176 VICTORIA AVENUE NORTH HAMILTON ON L8L 5G1

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

IRENE SCHMIDT (510a)

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): January 26 and 27, 2016.

Service delivery was observed, clinical records and policies were reviewed.

During the course of the inspection, the inspector(s) spoke with residents, registered staff, PSW instructors, director of care (DOC) and administrator.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

2 WN(s)
0 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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 licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents, was complied with. 2007, c. 8, s. 20 (1).

A) Review of the home's policy #OM-02-01-23 titled Resident Abuse and dated 14/10/15 (Y/M/D), under Procedure: Staff to Resident Abuse, item #3 directed that "the DOC and/or the Administrator will interview all parties and maintain a written record of same." The DOC confirmed that on an identified date, they were advised of allegations of staff to resident abuse that involved an identified number of residents and included staff denying care and fluids when requested by a resident and being disrespectful of resident property.
The DOC confirmed a written record of the investigation was not maintained as required by the home's policy on resident abuse.

B) Review of the home's policy #OM-02-01-23 titled Resident Abuse and dated 14/10/15 (Y/M/D), under Procedure: Staff to Resident Abuse, item #10, "the DOC is required to complete a Ministry of Health Critical Incident Report; immediately contact the ministry directly by telephone if indicated on the decision tree." The DOC confirmed that on an identified date, they were advised of an allegation of staff to resident abuse, as described above. The DOC confirmed a Ministry of Health Critical Incident Report was not submitted to the ministry as required by the home's policy on resident abuse. [s. 20. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident?
r. 97. (1) (b)
On an identified date, an allegation of staff to resident abuse was received by the DOC. The allegation involved an identified number of residents and included staff denying care and fluids when requested by a resident and being disrespectful of resident property. Review of the clinical record revealed the resident's substitute decision makers were not notified within 12 hours of the licensee becoming aware of the allegations, as confirmed by the DOC. [s. 97. (1) (b)]

Issued on this 4th day of April, 2016

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

Original report signed by the inspector.