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
Jan 17, Feb 7, 8, 9, 2012	2012_043157_0003	Complaint

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF KAWARTHA LAKES
26 Francis Streeet, LINDSAY, ON, K9V-5R8

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

VICTORIA MANOR HOME FOR THE AGED
220 ANGELINE STREET SOUTH, LINDSAY, ON, K9V-4R2

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

PATRICIA POWERS (157)

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, two Personal Support Workers and two Registered Nurses.

During the course of the inspection, the inspector(s) Reviewed the history of Critical Incidents related to resident Abuse and Neglect and the home's responsive actions, reviewed past Ministry of Health and Long Term Care inspection reports related to incidents of resident abuse and neglect, reviewed facility policies and procedures related to resident abuse and neglect, reviewed the home's staff education records.

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	Legendé
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. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

s. 20. (3) Every licensee shall ensure that the policy to promote zero tolerance of abuse and neglect of residents is communicated to all staff, residents and residents' substitute decision-makers. 2007, c. 8, s. 20 (3).

Findings/Faits saillants :

1. There is no evidence to indicate that the facility policy to promote zero tolerance of abuse and neglect of residents is communicated to residents and Substitute Decision-Makers.[s.20(3)]
2. The licensee has failed to comply with s.20(2)(d) in that the policy "Abuse of Residents", VM-ADM-016, dated June 19, 2009, does not contain an explanation of the duty under section 24 of the Act to make mandatory reports.
3.The facility's policy to promote zero tolerance of abuse and neglect of residents was not posted in a conspicuous and easily accessible location at the time of the inspection.[s.20(3)]
4. The licensee has failed to comply with s.20(2)(h) in that the policy "Abuse of Residents", VM-ADM-016, dated June 19, 2009, does not deal with any additional matters as may be provided for in the regulations as follows:
- The policy does not contain procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate [O.Reg.79/10 s.96(b)]
- The policy does not identify the manner in which allegations of abuse and neglect will be investigated including who will undertake the investigation and who will be informed of the investigation. [O.Reg.79/10 s.96(d)]
- The policy states "In some cases police will be notified of the alleged incident" but fails to specifically identify the requirements for notification of police [O.Reg.79/10 s.96(d)]
- The policy does not identify the home's responsibility to immediately notify the Director of a suspicion of abuse or neglect of a resident [O.Reg.79/10 s.96(d)]
- The policy does not identify the requirement to notify the resident's substitute decision maker immediately upon becoming aware of an alleged, suspected or witnessed incident of abuse or neglect [O.Reg.79/10 s.96(d)]
- Policy does not identify the training and retraining requirements for all staff related to the power imbalances between staff and residents and the potential for neglect by those in a position of trust, powers and responsibility for resident care [O.Reg.79/10 s.96(e)(i)]
- Policy does not identify training and retraining requirements related to situations that may lead to abuse and neglect and how to avoid such situations [O.Reg.79/10 s.96(e)(ii)]

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 home's policy to promote zero tolerance of abuse and neglect of residents meets the requirements of LTCHA, 2007, c.8,s.20 and O.Reg.79/10, s.96, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. An identified Critical Incident (CI) Report - There is no evidence that the Director was notified that, on March 14, 2011, the licensee had reasonable grounds to suspect that abuse of a resident may have occurred until a Critical Incident Report was submitted on March 17, 2011. [s.24(1)2.]
2. An identified CI Report - There is no evidence that the Director was notified that, on April 20, 2011, the licensee had reasonable grounds to suspect that abuse of a resident may have occurred until a Critical Incident Report was submitted on April 21, 2011.[s.24(1)2.]

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 a person who has reasonable grounds to suspect that abuse or neglect of a resident has occurred immediately reports the suspicion and information upon which it is based to the Director, to be implemented voluntarily.

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. (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. An identified CI indicates that the licensee received information about an alleged abuse of a resident and the home's investigation records indicate the resident's substitute decision-maker was not notified of the allegations of abuse until five days later. [r.97(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 the resident's substitute decision-maker is 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 physical injury or pain to the resident or that causes distress to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. Two identified CI reports - There is no evidence that an analysis of these incidents was undertaken.[r.99(a)]
2. There is no evidence of an annual evaluation to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents. [r.99(b)]

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 an analysis of every incident of abuse of neglect of a resident is undertaken and to ensure that an annual evaluation of the licensee's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #5: 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 subsections:

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:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
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.
5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. Two identified CI Reports - Reports do not identify staff members who were present at the time of the reported incidents.[104(1)2.ii]

Issued on this 9th day of February, 2012

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