Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 22, 2021	2021_815623_0018	006029-21, 007137-21, 007286-21, 012077-21, 012598-21, 013176-21	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the City of Kawartha Lakes
26 Francis Streeet P.O. Box 9000 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

SARAH GILLIS (623)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 17, 20 - 24, 28, 29, October 6 - 8, 12 and 13, 2021

The following intakes were inspected concurrently:
Follow Up to CO#1 from report #2021_643111_0005 for s. 5., Compliance Due Date Jun 30, 2021
Two Critical Incident Reports related to resident to resident physical abuse
A Critical Incident Report related to a hypoglycemic event
A Critical Incident Report related to an allegation of neglect
A Critical Incident Report related to an allegation of staff to resident emotional abuse

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Associate Directors of Care (ADOC), Registered Nurses (RN), Registered Practical nurses (RPN), Personal Support Workers (PSW), Housekeepers, Dietary Aides, and residents.

The Inspector also reviewed the licensee's internal investigation records, resident health care records, education records, observed housekeeping services, reviewed applicable policies, observed the delivery of resident care and services, including staff to resident interactions. Infection Prevention and Control practices in the home were also observed and reviewed.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 5.	CO #001	2021_643111_0005	623

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	Légende 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan related to continence care for resident #006.

A Critical Incident Report was submitted to the Director which indicated that when the evening staff arrived on shift, they reported that resident #006 was discovered lying in bed and appeared to have not received continence care for an extended period of time.

Review of the plan of care for resident #006 including the Kardex, indicated that the resident required extensive assistance of two staff to assist with continence care and staff were to check the resident for continence upon rising, after meals and before bed, with product change and care as necessary.

During an interview PSW #119 indicated that they were the primary care provided on that date for resident #006. The PSW indicated that they did not recall checking the resident after their morning rounds. During that round the resident did not require continence care. PSW #119 indicated that residents are supposed to be checked every two hours, resident #006 was observed for safety but not checked for continence. The PSW confirmed they did not follow the plan of care that day and continence care was not provided to resident #006 in accordance with the plan.

When continence care was not provided to resident #006 as specified in the plan, the resident was at risk for skin breakdown.

Sources: Critical Incident Report, internal investigation records, clinical records for resident #006, related policies, staff interviews. [s. 6. (7)]

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 by ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 failed to ensure that the homes written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A Critical Incident Report (CIR) was submitted to the Director for an allegation of abuse that occurred eight days prior. The CIR indicated that on an identified date, resident #007 reported to PSW #121 that PSW #120 had been physically and verbally abusive towards the resident when providing care the day prior. Resident #007 reported to PSW #121 six days later, that they were still experiencing pain from when PSW #120 “hit them”. PSW #121 did not report the allegation until the following day.

The homes policy Prevention of Abuse & Neglect of a Resident (current version April 2021) indicates that all team members and families with reasonable grounds to suspect or witness abuse of a resident are required to immediately report to the Executive Director/Manager on duty and the Nurse in charge in the care community.

During the licensee's investigation PSW #121 confirmed they did not immediately report the allegation of abuse when resident #007 reported it to them. The resident told PSW #121 it was just an accident and did not want it reported. When the resident mentioned it a second time several days later, PSW reported the allegations the following day. ADOC #102 indicated the expectation of the licensee is that all suspected, alleged or witnessed abuse would be immediately reported and PSW #121 did not follow the policy.

When PSW #121 did not immediately report the allegation of abuse by resident #007, it placed the resident at risk for further abuse.

Source: Critical Incident Report, licensee’s internal investigation, Prevention of Abuse & Neglect Policy, staff interviews. [s. 20. (1)]

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 by ensuring that the homes written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

Issued on this 16th day of November, 2021

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

Original report signed by the inspector.