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
Jun 12, 2013	2013_179103_0024	O-000016-13	Critical Incident System

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9

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

THE VILLAGE GREEN NURSING HOME
166 Pleasant Drive, P.O. Box 94, Selby, ON, K0K-2Z0

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

DARLENE MURPHY (103)

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): June 3, 10, 11, 12, 2013

During the course of the inspection, the inspector(s) spoke with a Resident, Personal Support Workers (PSW), a Registered Nurse (RN), and the Administrator.

During the course of the inspection, the inspector(s) reviewed resident health care records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

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. 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 :

1. The licensee has failed to comply with LTCHA s. 6 (7) whereby the care set out in the resident plan of care was not provided to the resident as specified in the plan.

On an identified date, PSW staff responded to Resident #1's request to be toileted. During an interview with the resident, it was indicated staff attempted to use a bed pan and that the resident's preference was to be toileted using the commode at the bedside.

Resident #1's plan of care related to continence and toileting was reviewed. In the care plan in effect at the time of the incident, it indicated the resident was toileted using the commode at the bedside and made no mention of using a bedpan as a part of the toileting routine.

The staff involved were reprimanded by the home for failure to follow the resident plan of care in providing toileting and continence care. [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 to ensure Resident #1's plan of care related to continence care will be followed, 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:

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. 2007, c. 8, ss. 24 (1), 195 (2).
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. 2007, c. 8, ss. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 24 (1), 195 (2).
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. The licensee has failed to comply with LTCHA, s. 24 (1) whereby an alleged incident of abuse which resulted in harm to a resident was not immediately reported to the Director.

RN staff #100 was interviewed and indicated on an identified date, a PSW reported that during morning care he/she noted that Resident #1 had bruising. The PSW indicated that Resident #1 believed staff had caused the bruising while they were assisting with toileting. Staff #100 provided the PSW with a witness statement which the staff member completed. The RN then placed the witness statement in the Administrator's mailbox despite knowing the Administrator would not be returning to work until two days later.

In an interview with the Administrator, she indicated it is an expectation that staff notify the Administrator or the Director of Care immediately with any allegations of abuse so that the appropriate actions can be taken. [s. 24. (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 to ensure a person who has reasonable grounds to suspect the abuse of a resident which resulted in harm or risk of harm to the resident immediately reports the suspicion to the Director, to be implemented voluntarily.

WN #3: 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 has failed to comply with LTCHA s. 23 (1) (a) whereby an alleged incident of abuse was not immediately investigated.

The Administrator advised that she received a witness statement on an identified date which indicated a resident had received bruises as a result of two nurses during toileting. The investigation into the allegations were initiated two days later. [s. 23. (1) (a)]

WN #4: 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 comply with O. Reg 79/10 s. 97 (1) (a) whereby the resident's substitute decision maker was not notified immediately of an alleged incident of abuse which resulted in harm to the resident.

In an interview with RN staff #100, it was indicated he/she received information that Resident #1 had been "roughly handled" by staff and had resulted in bruising on an identified date. A witness statement was completed but the RN did not notify the family in regards to the allegations at that time.

The Administrator was made aware of the allegations of abuse two days later, but did not notify family for an additional two days. [s. 97. (1) (a)]

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Issued on this 12th day of June, 2013

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