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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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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
Apr 3, 2014	2014_266527_0004	H-000020-13	Complaint

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

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

THE VILLAGE OF SANDALWOOD PARK
425 Great Lakes Drive, BRAMPTON, ON, L6R-2W8

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

KATHLEEN MILLAR (527)

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 29, 30, 31 and February 5, 10, 11, 12, 2014

The inspection conducted was a Complaint Inspection Log #: H-000020-13 related to medication administration, responsive behaviours and the plan of care.

During the course of the inspection, the inspector(s) spoke with Residents, Resident's family members/Power of Attorney, Registered Nursing staff, Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Kinesiologist, Physiotherapist, Physiotherapist Assistant, Nutrition staff, Students, Behavioural Support Officer (BSO), Activation staff, the Director of Nursing, the previous Acting General Manager, the Director of Human Resources, and the current General Manager.

During the course of the inspection, the inspector(s) observed resident and staff interactions, observed dining, observed medication administration, observed the provision of resident care; interviewed residents, family members/POA and staff; and reviewed health records, policies/procedures, and training/educational records and programs.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Dining Observation
Medication
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. 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, s. 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, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 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, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to immediately report to the Director the suspicion of resident abuse that could have resulted in harm or risk of harm to a resident.

(a) The home was informed by the daughter of another resident of the suspected abuse at a meeting in November 2012. The visitor stated she saw a staff member slap the resident. After being informed, the home proceeded to investigate.

(b) In reviewing the home's critical incident log, there was no critical incident report immediately submitted to the Director. This was confirmed in an interview with the Acting General Manager and the Director of Human Resources. The Director of Nursing was interviewed and she was unsure if the abuse of the Resident was reported to the Director. The home was unable to find a critical incident report.

(c) The Registered Nurse (RN) confirmed she witnessed the physical and verbal abuse of the Resident in May 2012. She stated the PSW slapped the resident twice. The PSW was witnessed talking to the resident in a loud and reprimanding voice. Confirmed in the RNs personal notes she provided details of the abuse of the Resident at the time it occurred.

(d) In December 2012 the home interviewed an RPN student. The student also witnessed the abuse of the Resident. Based on the investigative notes from the interview, the student remembered the PSW slapped the resident and was talking to the resident as if she was trying to embarrass the resident.

The home failed to immediately report to the Director the suspected abuse of a Resident once they became aware of the incident. [s. 24. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

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Findings/Faits saillants :

1. The Licensee did not ensure staff compliance with the home's policy on the Prevention of Abuse policy.

(a) The Resident was physically and verbally abused by a staff member in May 2012. The RN who was in charge of the unit, and the student nurse witnessed the resident abuse by a staff member and did not report it to the home. This was confirmed in an interview with the RN.

(b) The home's Prevention of Abuse policy #04-06 dated November 2011 was reviewed and it outlines the procedure for reporting witnessed or suspected abuse internally, and the mandatory reporting obligations.

(c) Confirmed with the Director of Care and Administrator that staff attended the annual education program and received training on the home's expectations of staff to report suspected or actual abuse.

(d) Reviewed training records for March and April, 2012 which indicated staff had received mandatory training in the Prevention of Abuse and Neglect and reporting expectations. Confirmed with the Administrator that staff also utilized the Marketplace training program in October, November and December of 2012 to complete mandatory training in the Prevention of Abuse and Neglect.

(e) The Director of Care confirmed that during the orientation of new student nurses and their instructors, they are trained on the home's Prevention of Abuse policies and procedures.

The home's staff and the student nurse did not follow the policies and procedures of the home by not reporting the physical and verbal abuse of a Resident. [s. 8.]

Issued on this 4th day of April, 2014

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

Kathleen Miller

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KATHLEEN MILLAR (527)
Inspection No. / No de l'inspection :	2014_266527_0004
Log No. / Registre no:	H-000020-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 3, 2014
Licensee / Titulaire de permis :	OAKWOOD RETIREMENT COMMUNITIES INC. 325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	THE VILLAGE OF SANDALWOOD PARK 425 Great Lakes Drive, BRAMPTON, ON, L6R-2W8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ZOHORA MOHAMMED

To OAKWOOD RETIREMENT COMMUNITIES INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2013_205129_0004, CO #007;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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, s. 24 (1), 195 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan of corrective action to ensure that when there are reasonable grounds to suspect that a resident has been abused by anyone, that this suspicion is immediately reported to the Director. The plan is to be submitted by May 12, 2014 by mail to Kathleen Millar, Nursing Inspector, Ministry of Health and Long Term Care, 119 King Street West, 11th Floor, Hamilton, Ontario L8P 4Y7, or by email at: kathy.millar@ontario.ca.

Grounds / Motifs :

1. The licensee failed to immediately report to the Director the suspicion of resident abuse that could have resulted in harm or risk of harm to a resident.

(a) The home was informed by the daughter of another resident of the suspected abuse at a meeting in November 2012. The visitor stated she saw the staff member slap the resident. After being informed, the home proceeded to investigate.

(b) In reviewing the home's critical incident log, there was no critical incident report. This was confirmed in an interview with the Acting General Manager and the Director of Human Resources. The Director of Nursing was interviewed and she was unsure if the abuse of the Resident was reported to the Director. The home was unable to find a critical incident report.

(c) The Registered Nurse confirmed she witnessed the physical and verbal abuse of the Resident in May 2012. She stated the PSW slapped the resident on the buttocks and then slapped her again. The PSW was also talking to the resident in a loud and reprimanding voice. The RN also confirmed that her personal notes provided to the home explains the details of the abuse of the Resident at the time it occurred.

(d) In December 2012 the home interviewed an RPN student. The student witnessed the abuse of the Resident. Based on the investigative notes from the interview, the student remembered the PSW slapped the resident on the back and was talking to the resident as if she was trying to embarrass the resident.

The home failed to immediately report to the Director the suspected abuse of the Resident once they became aware of the incident. (527)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 3rd day of April, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kathleen Millar

Service Area Office /
Bureau régional de services : Hamilton Service Area Office