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

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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347 Preston St, 4th Floor
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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
Jun 28, 29, Jul 3, 4, 5, 2012	2012_041103_0023	Critical Incident

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

WEST LAKE TERRACE
1673 COUNTY ROAD, 12, R. R. #1, PICTON, ON, K0K-2T0

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 inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care, The Administrator, a Registered Nurse, the Life Enrichment Manager, Personal support workers. an Ontario Provincial Police constable and a Community Care case manager.

During the course of the inspection, the inspector(s) did a walk-through of the home, reviewed the home's policy on abuse and reviewed resident health care records. The log number for this inspection was O-001395-12.

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. 19. Duty to protect

Specifically failed to comply with the following subsections:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA s. 19 (1) whereby a resident was not protected from abuse by a co-resident.

Resident #1 is dependent on staff for all aspects of his/her physical care. The resident is not capable of ringing a call bell or calling out for help.

Resident #2 shares a room with Resident #1.

On an identified date, Registered Nurse, staff #100 walked into Resident #1's room and witnessed Resident #2 sexually assaulting Resident #1.
-Staff #100 advised Resident #2 that this behavior was inappropriate and abusive. She asked Resident #2 to come with her, but the resident laid on his/her bed with his/her back to the staff member and did not comply.
-Staff #100 believed Resident #2 would not pose a further risk to Resident #1 after the comments she had made to him/her and decided to leave him/her in the room.
-Staff #100 then advised all staff working of the incident and instructed them to make checks every twenty to thirty minutes to monitor resident #2.
-Staff #100 advised it was a busy day and stated she believed moving Resident #2 to the infirmary would have meant he/she was less visible to staff. There was no decision made to move Resident #1 to an alternative location.
-Staff #100 reported Resident #1's demeanor was more withdrawn following the incident.
-The Life Enrichment manager who was on call on the identified date was interviewed. She indicated she came to the home to follow up on the reported incident of abuse and indicated she had a very good rapport with Resident #1. She noted he/she was tearful which indicated to her that he/she knew what had happened.
At a specified time, the Life Enrichment Manager and the Administrator entered the resident room again. They both reported that Resident #2 was once again standing at Resident #1's bed and was holding up the bed covers. Resident #2 stated he/she was just covering up Resident #1. At that time, the Administrator told Resident #2 he/she needed to leave the room and proceeded to escort the resident to the infirmary where a staff member was assigned to ensure he/she did not leave the room unattended.

The home failed to separate vulnerable Resident #1 from his/her abuser. A second incident of abuse was observed by the Administrator and the Life Enrichment Manager to have either occurred or be about to occur when they found the abuser standing over the victim for a second time on the identified date of the incident. The victim had been left in the same room as the abuser for more than five hours and the victim was reported to be tearful and withdrawn and unable to call out for assistance or support.

Resident #1 experienced ongoing distress related to these incidents. The physician examined Resident #1 two days later and noted he/she was not as responsive and had a flattened affect. At the end of the examination, the physician indicated to the resident that he/she was safe and the other resident was taken away by police. The resident responded with a "yeah" which the physician believed indicated the resident had suffered from the traumatic event.
Staff #100 and the Life Enrichment Manager both indicated Resident #1 did not appear to be his/her usual self for at least one week following the incident.
The home did arrange for the Sexual Assault Centre to come to the home to provide support to both Resident #1 and the staff. The Director of Care indicated Resident #1 was crying during the assessment which she believed indicated he/she was aware of the incident.

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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following subsections:

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 the written policy to promote zero tolerance of abuse and neglect of residents was followed.

West Lake Terrace have a Policy "Reporting Incidents of Abuse #AM-". The policy indicates:
-"A resident's family or substitute decision maker shall be contacted to inform them of any alleged, suspected or witnessed incident of abuse or neglect immediately after it is reported.
-"the police shall be contacted to inform them of any alleged, suspected or witnessed incident of abuse or neglect of a resident immediately after it is reported.
-Upon becoming aware of abuse of a resident, the home shall contact the Ministry of Health immediately.

On an identified date, there was a witnessed sexual abuse of a resident. The police and the Ministry of Health were notified approximately three hours after the time of the incident. The Substitute Decision maker for Resident #1 was notified approximately six hours after the incident.

West Lake Terrace also has a policy "Abuse of residents by residents, 2.4" which indicates, "in cases where a staff member witnesses an act of abuse by a resident to another resident, the first step in dealing with the issue is, where possible, separate the residents involved and ensure both residents are safe. If separating the residents is not possible, immediately call for help."

The home failed to separate vulnerable resident #1 from his abuser.

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 direct care nursing staff, both registered and non-registered follow the home's abuse policy, to be implemented voluntarily.

Issued on this 11th day of July, 2012

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

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

Ministére 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) :	DARLENE MURPHY (103)
Inspection No. / No de l'inspection :	2012_041103_0023
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Jun 28, 29, Jul 3, 4, 5, 2012
Licensee / Titulaire de permis :	OMNI HEALTH CARE LIMITED PARTNERSHIP 1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9
LTC Home / Foyer de SLD :	WEST LAKE TERRACE 1673 COUNTY ROAD, 12, R. R. #1, PICTON, ON, K0K-2T0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MARY LYNN LESTER

To OMNI HEALTH CARE LIMITED PARTNERSHIP, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Ministére 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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with LTCHA, s. 19 (1). The compliance plan shall include how the licensee will ensure residents are protected from abuse and will include an educational plan for all direct care nursing staff (registered and non-registered) to ensure policies and procedures related to abuse are followed .

The plan must be submitted in writing to Inspector, Darlene Murphy at 347 Preston Street, 4th floor, Ottawa, ON K1S 3J4 or by fax at 613-569-9670 on or before July 13, 2012.

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA s. 19 (1) whereby a resident was not protected from abuse by a co-resident.

Resident #1 is dependent on staff for all aspects of his/her physical care. The resident is not capable of ringing a call bell or calling out for help.

Resident #2 shares a room with Resident #1.

On an identified date, Registered Nurse, staff #100 walked into Resident #1's room and witnessed Resident #2 sexually assaulting Resident #1.
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-Staff #100 believed Resident #2 would not pose a further risk to Resident #1 after the comments she had made to him/her and decided to leave him/her in the room.
-Staff #100 then advised all staff working of the incident and instructed them to make checks every twenty to thirty minutes to monitor resident #2.
-Staff #100 advised it was a busy day and stated she believed moving Resident #2 to the infirmary would have meant he/she was less visible to staff. There was no decision made to move Resident #1 to an alternative location.
-Staff #100 reported Resident #1's demeanor was more withdrawn following the incident.
-The Life Enrichment manager who was on call on the identified date was interviewed. She indicated she came to the home to follow up on the reported incident of abuse and indicated she had a very good rapport with Resident #1. She noted he/she was tearful which indicated to her that he/she knew what had happened.
At a specified time, the Life Enrichment Manager and the Administrator entered the resident room again. They both reported that Resident #2 was once again standing at Resident #1's bed and was holding up the bed covers. Resident #2 stated he/she was just covering up Resident #1. At that time, the Administrator told Resident #2 he/she needed to leave the room and proceeded to escort the resident to the infirmary where a staff member was assigned to ensure he/she did not leave the room unattended.

The home failed to separate vulnerable Resident #1 from his/her abuser. A second incident of abuse was observed by the Administrator and the Life Enrichment Manager to have either occurred or be about to occur when they found the abuser standing over the victim for a second time on the identified date of the incident. The victim had been left in the same room as the abuser for more than five hours and the victim was reported to be tearful and withdrawn and unable to call out for assistance or support.

Resident #1 experienced ongoing distress related to these incidents. The physician examined Resident #1 two days later and noted he/she was not as responsive and had a flattened affect. At the end of the examination, the physician indicated to the resident that he/she was safe and the other resident was taken away by police. The resident responded with a "yeah" which the physician believed indicated the resident had suffered from the traumatic event.
Staff #100 and the Life Enrichment Manager both indicated Resident #1 did not appear to be his/her usual self for at least one week following the incident.
The home did arrange for the Sexual Assault Centre to come to the home to provide support to both Resident #1 and the staff. The Director of Care indicated Resident #1 was crying during the assessment which she believed indicated he/she was aware of the incident. (103)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 06, 2012

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
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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

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

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.

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

Ministére 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

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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 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 5th day of July, 2012

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DARLENE MURPHY

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