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
Mar 1, 2013	2013_027192_0003	H-000068-13, H-000088-13	Critical Incident System

Licensee/Titulaire de permis

HALTON HEALTHCARE LTC INC.
327 REYNOLDS STREET, OAKVILLE, ON, L6J-3L7

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

WYNDHAM MANOR LONG TERM CARE CENTRE
291 REYNOLDS STREET, OAKVILLE, ON, L6J-3L5

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

DEBORA SAVILLE (192)

Inspection Summary/Résumé de l'inspection

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

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

This inspection was conducted on the following date(s): February 26, 27, and 28, 2013

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers and residents.

During the course of the inspection, the inspector(s) toured the home area and reviewed investigation notes, medical records, and policy and procedure.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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:

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 failed to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Previously issued June 2011 (WN) and January 2012 (CO).

In 2013 a social worker entered resident 001's room and found them to be in a state of "emotional distress". It was reported by the resident to the social worker that they felt horrible because a Personal Support Worker (PSW) was so rough and because of comments made to them. The resident was able to name the staff member and explain the specifics of care provided, indicating rough handling and being spoken to in a demeaning manner. The resident reports that the way they were treated during care in 2013 made them feel distressed.

Interview with the social worker confirms that the resident was emotionally distressed by the actions of the specified care giver and required 1:1 attention to vent concerns and receive reassurance.

An interview conducted by the home, with the resident, indicates that the staff member had treated them roughly during care. The staff member made statements like "all you do is cry for nothing" which caused distress to the resident.

Resident interview confirms that an incident occurred related to the specified staff member. Although the resident is unable to recall specifics one month after the incident, they are able to clearly recall the name of the staff member and stated that the care giver was rough and uncaring. In speaking about the incident the resident's actions become animated and an emotional response is evident.

In 2013 resident 001 was verbally abused by a specified staff member resulting in emotional distress for the resident. [s. 19. (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 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. A person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm failed to immediately report the suspicion and the information upon which it was based to the Director.

a) In 2013 the social worker of the home documented that they had received information from resident 001 indicating that a staff member of the home had treated them roughly, in a hurried manner and had made comments that resulted in emotional distress for the resident.

This information was not communicated immediately to the Director as required under the LTCHA, 2007 s. 24(1).

The information was communicated to the Executive Director of the home via e-mail sent on the day it was reported in 2013, but was not received until four days following the reported abuse. The incident was not reported to the Director until 10 days following the first report from the resident.

b) Interview with several Personal Support Workers (PSW) of the home identified that a particular staff member was frequently rough when providing care, abrupt in their tone, words and actions toward residents and that residents frequently demonstrated fear when in the staff members presence. It was reported that on occasion the staff member was observed slapping residents and residents were heard to say "don't hit me".
These allegations of potential abuse were confirmed in interviews conducted by the home. The Executive Director and Director of Care confirmed in interview that they had not been made aware of these actions until the 2013 incident involving resident 001. No investigation was conducted and no action had been taken to protect residents of the home from the specified staff member. The actions of a specified staff member, that resulted in emotional distress for residents of the home, were not reported immediately to the Director.

Registered Staff interview identified that the specified staff member had been witnessed slapping a resident across the head and telling them to hurry up. The Registered staff member stated she had "written up" the identified staff member for this incident but the home is unable to provide a record of the incident. Interview with the Director of Care indicates she was not aware of the incident and no investigation

was conducted. There was no report of this incident to the Director.

During interview a PSW indicated that in June or July 2012 they observed the specified staff member kick a resident in the foot while providing care. Interview confirms that this incident was not reported to management of the home, the resident was not assessed for injury and there was no report of the incident to the Director.

Several staff of the home identified potentially harmful actions of a particular staff member and the impact these actions had on residents of the home. All failed to report the improper treatment and the potential abuse of residents of the home immediately to the Director. [s. 24. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Staff interviewed in 2013 indicated that they had, on several occasions, observed care being provided to residents of the home area, in a hurried, rough manner by a particular staff member. Each staff member interviewed indicated they had also observed verbal abruptness directed at various residents on the home area. Review of interview notes conducted by the home confirms these statements.

Interview with registered staff in 2013 indicated that an identified staff member had been observed slapping a resident of the home across the head and telling the resident to hurry up.

Residents of the home were not treated with courtesy and respect. [s. 3. (1) 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 ensuring that every resident is treated with courtesy and respect in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

Issued on this 18th day of March, 2013

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

Debora Saville

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) :	DEBORA SAVILLE (192)
Inspection No. / No de l'inspection :	2013_027192_0003
Log No. / Registre no:	H-000068-13, H-000088-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 1, 2013
Licensee / Titulaire de permis :	HALTON HEALTHCARE LTC INC. 327 REYNOLDS STREET, OAKVILLE, ON, L6J-3L7
LTC Home / Foyer de SLD :	WYNDHAM MANOR LONG TERM CARE CENTRE 291 REYNOLDS STREET, OAKVILLE, ON, L6J-3L5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SUSIE MACIEL

To HALTON HEALTHCARE LTC INC., 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

Ministére de la Santé et des Soins de longue durée

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

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) (a) (b) CB

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 and submit a plan ensuring that residents of the home are free from abuse and neglect.
The plan shall include, but shall not be limited to:

1. Training related to the types of abuse
2. Quality Improvement initiatives to ensure the effectiveness of training.

The plan shall be implemented
The plan shall be submitted electronically to Debora Saville, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Hamilton Service Area Office at debora.saville@ontario.ca by March 6, 2013.

Grounds / Motifs :

1. 1. The licensee failed to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Previously issued June 2011 (WN) and January 2012 (CO).

In 2013 a social worker entered resident 001's room and found them to be in a state of "emotional distress". It was reported by the resident to the social worker that they felt horrible because a Personal Support Worker (PSW) was so rough and because of comments made to them. The resident was able to name the staff member and explain the specifics of care provided, indicating rough handling and being spoken to in a demeaning manner. The resident reports that the way they were treated during care in 2013 made them feel distressed.

Interview with the social worker confirms that the resident was emotionally distressed by the actions of the specified care giver and required 1:1 attention to vent concerns and receive reassurance.

An interview conducted by the home, with the resident, indicates that the staff member had treated them roughly during care. The staff member made statements like "all you do is cry for nothing" which caused distress to the resident.

Resident interview confirms that an incident occurred related to the specified staff member. Although the resident is unable to recall specifics one month after the incident, they are able to clearly recall the name of the staff member and stated that the care giver was rough and uncaring. In speaking about the incident the resident's actions become animated and an emotional response is evident.

In 2013 resident 001 was verbally abused by a specified staff member resulting in emotional distress for the resident. [s. 19. (1)] (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 15, 2013

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 : 002

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

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, ss. 24 (1), 195 (2).

Order / Ordre :

The licensee shall prepare and submit a plan ensuring that all staff of the home are aware of reporting requirements related to suspected or witnessed abuse or neglect, and respond when witnessing reportable incidents. The plan shall include but shall not be limited to:

i) what constitutes a reportable incident
ii) knowledge of the homes reporting hierarchy,
iii) how reporting is to be completed,
iv) actions to take if concerns are not acted upon immediately

The plan shall be implemented.
The plan shall be submitted electronically to Debora Saville, Long Term Care Home Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, Hamilton Service Area Office, at debora.saville@ontario.ca by March 6, 2013.

Grounds / Motifs :

1. 1. A person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of

harm failed to immediately report the suspicion and the information upon which it was based to the Director.

a) In 2013 the social worker of the home documented that they had received information from resident 001 indicating that a staff member of the home had treated them roughly, in a hurried manner and had made comments that resulted in emotional distress for the resident.

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Several staff of the home identified potentially harmful actions of a particular staff member and the impact these actions had on residents of the home. All failed to report the improper treatment and the potential abuse of residents of the home immediately to the Director. [s. 24. (1)] (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 15, 2013

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 1st day of March, 2013

Signature of Inspector / Signature de l'inspecteur : Debora Saville

Name of Inspector / Nom de l'inspecteur : DEBORA SAVILLE

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