**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 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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| Date(s) of inspection/Date(s) de l'inspection | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| Jul 13, 14, 21, Nov 30, 2011 | 2011_061129_0002 | Mandatory Reporting |

**Licensee/Titulaire de permis**

ST. PETER'S CARE CENTRES
125 Redfern Ave, HAMILTON, ON, L9C-7W9

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

ST. PETER'S RESIDENCE AT CHEDOKE
125 Redfern Avenue, HAMILTON, ON, L9C-7W9

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

PHYLLIS HILTZ-BONTJE (129)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Mandatory Reporting inspection.**

**During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Resident Care, Assistant Director of Care, Resident Advisor and Registered Nursing staff. (H-001322-11)**

**During the course of the inspection, the inspector(s) The following documents were reviewed: the resident's clinical record, notes taken by the Nursing leaders during their review of the incident and the home's abuse policy.**

**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<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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 failed to protect an identified resident from abuse by an identified Personal Support Worker(PSW). [s. 19 (1)]

Staff in the home reported that an identified PSW assigned to provide care to the resident abuse the resident during a care episode. The home reports that staff in the home made allegations that this identified PSW had abused four other residents in the past. The home also reported that they investigated allegations of abuse by this identified PSW a year ago and were unable to conclude that abuse had taken place.

**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 failed to ensure that the homes policy #2-60 "Non-Abuse of Residents dated January 16, 2011 and last revised in October 2010 is complied with, related to:[s. 20(1)]

a) The policy states "All staff has an obligation to report any act of resident abuse" and " All incidents of resident abuse must be reported immediately to a member of the Leadership Team or the Nurse in Charge". PSW staff did not immediately report an alleged incident of abuse for an identified resident. The report of this incident was made to the nurse in-charge six days following the incident. During the course of the home investigating this incident, PSW staff also reported incidents of abuse that had occurred over a month earlier that involved four other residents in the home and the same PSW.

b) The policy states "The resident's substitute decision maker (SDM) will be made aware immediately of an alleged, suspected or witnessed incident of abuse or neglect ....." Allegations of abuse of an identified resident were reported by PSW staff in the home and these allegations were not communicated to the SDM for four days. Further allegations of the abuse of four other residents, as a result of the investigation into the above noted allegations and reported to the home were not communicated to the respective SDM's for 14 day following the allegations being made.

c) The policy states, "Where sufficient evidence exists to substantiate an allegation of abuse the Administrator or delegate will notify the family, MOHLTC and if appropriate, other authorities, including the police force if the incident could constitute a criminal offence."
Staff in the home conducted an investigation into the allegations of abuse of the identified resident, completed the investigation, substantiated the allegations of abuse and took actions as a result of the outcome of the investigation. Police were not contacted with respect to this incident of abuse or the allegations of abuse of 4 other resident's that the home became aware of during the course of the investigation noted above.

d) The policy states "the resident who has been the victim of abuse will be visited by the Resident Advisor on the next business day. If the Resident Advisor assesses a need for further interventions, community resources will be contacted for counseling services". The Social Worker/Resident Advisor confirmed that she did not visit the identified resident following the allegations of abuse and that she was unaware that the allegations had been made. She also confirmed that she had not visited the 4 other residents for which allegations of abuse where reported during the course of the home's investigation into this incident.

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**WN #3: 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 subsections:**

**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).**

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**Findings/Faits saillants :**

1. The licensee failed to immediately notify the Director of allegations of abuse of an identified resident in the home. PSW staff reported allegations of abuse to the in-charge Registered Nurse (RN). The Hamilton Service Area Office received notification of these allegations of abuse through the Critical Incident Reporting system 4 days after the allegations had been made.
The home failed to immediately report to the Director allegations of abuse made by staff for four other residents identified during the course of this investigation.

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**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 subsections:**

**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 failed to notify an identified resident's Substitute Decision Maker(SDM) following allegations of abuse of the resident. Interview notes written by the Assistant Director of Care(ADOC) indicate that the resident's SDM was notified of the allegations a month after the allegations were identified.

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.**

**Findings/Faits saillants :**

1. The licensee failed to contact the appropriate police force following Personal Support Worker(PSW) staff in the home reporting allegations of abuse to in-charge staff.

**Issued on this 30th day of November, 2011**

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