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
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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 20, 2014	2013_215123_0024	H-000706-13	Critical Incident System

Licensee/Titulaire de permis

SPECIALTY CARE MISSISSAUGA INC.
400 Applewood Crescent, Suite 110, VAUGHAN, ON, L4K-0C3

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

SPECIALTY CARE MISSISSAUGA ROAD
4350 MISSISSAUGA ROAD, MISSISSAUGA, ON, L5M-7C8

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

MELODY GRAY (123)

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): December 17, 18, and 20, 2013

Concurrent inspection #2013_215123_0023

During the course of the inspection, the inspector(s) spoke with residents, the home's management staff, registered staff, and Personal Support Workers (PSW).

During the course of the inspection, the inspector(s) observed staff-resident interactions, reviewed the home's records including the policies and procedures and reviewed the resident's record.

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 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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 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 is treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
The home's records including; the incident report, the investigation records and the policies and procedures Abuse and Neglect of a Resident - Actual or Suspected #VII-G-10.00 and Definitions of Abuse #VII-G-10.00(a) were reviewed. The home's records noted that in October 2013 an identified resident #002 reported to a registered staff member that they were not treated in a courteous and respectful way by a staff member. The identified resident #002 alleged that the staff was very grumpy and rude when they responded to their request for assistance. The resident claimed that the staff questioned their request for assistance; did not provide appropriate assistance and that the staff got angry at them and grumbled the whole time they provided the assistance. The home's investigation records indicated that the resident and staff were interviewed. The home verified the resident's allegations; found that the staff violated the Residents' Bill of Rights and actions were taken by the home as per the home's policies and procedures.
The home's Administrator was interviewed and confirmed the information in the home's records; that the resident reported the incident to the home and that the home's investigation found that the resident's allegations were substantiated.
The home failed to ensure that the resident was treated with courtesy and respect and in a way that fully recognized their individuality and respected their dignity. [s. 3. (1) 1.]

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, 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 ensure that a person who has reasonable grounds to suspect any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it it is based to the Director. (2). Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk or harm to the resident.
An identified resident #002 was allegedly abused by a staff member in October 2013. On October 9, 2013 a staff member reported to the Associate Director of Care (ADOC) that the identified resident #002 was upset and had concerns about a staff member's approach when the resident #002 requested assistance. A report of the alleged abuse was submitted to the Director on October 11, 2013.
The home failed to ensure that 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. [s. 24. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1).

On October 11, 2013 the home submitted a report to the Director related to allegations of staff-to-resident abuse involving an identified resident #002. It is noted in the incident report that a relative of the identified resident #002 also wrote a complaint about the same incident. The home's Administrator was interviewed and confirmed that the written complaint was received by the home as per the incident report and that the written concern was not submitted to the Director as required.

The home failed to ensure that every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1) [s. 103. (1)]

Issued on this 20th day of March, 2014

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