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
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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
Sep 17, 2014	2014_250511_0017	H-000846-14	Critical Incident System

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF HALTON
1151 BRONTE ROAD, OAKVILLE, ON, L6M-3L1

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

CREEK WAY VILLAGE
5200 Corporate Drive, BURLINGTON, ON, L7L-7G7

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

ROBIN MACKIE (511)

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): August 14 and 15, 2014

During the course of the inspection, the inspector(s) spoke with the Manager of Resident Care, Director of Nursing and Personal Care, registered nursing staff, Personal Support Worker (PSW), recreational staff, resident and family member.

During the course of the inspection, the inspector(s) reviewed clinical records, applicable policy and procedure and observed the provision of resident care.

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.) 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 has failed to ensure that resident #001 was protected from abuse by anyone and free from neglect by staff of the home.

A review of the home's critical incident report, submitted in December, 2013, indicated an allegation of abuse occurred within the home in December, 2013 to resident #001. A review of the home's administrative records identified an allegation of abuse and neglect was brought forth by a staff member in December, 2013. The staff member reported to the home that they heard another staff member speak in an inappropriate manner to resident #001 on a day in December, 2013. Review of the investigative records and interview with the Manager of Resident Care confirmed the staff member heard another staff member speaking, in a harsh and rude tone, to resident #001's request to be toileted. Resident #001's December Plan of Care indicated the resident had a number of debilitating conditions and relied on the staff for toileting. Resident #001 was continent of their bowel and bladder during the day time, would request to be toileted, required total 2 person assistance with a mechanical lift for transfers and extensive assistance for other activities of daily living. The home's internal investigation determined the incident constituted verbal abuse and neglect confirming the comments to be belittling and degrading (as per the home's definition of verbal abuse) to resident #001 and had implemented their Prevention, Reporting and Elimination of Abuse and Neglect Policy (#01-05-03). The alleged employee was no longer employed by the home at the time of this inspection. The Director of Nursing confirmed the home had not protected resident #001 from abuse and neglect by a staff in the home. [s. 19. (1)]

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:

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 that where there was a written policy that promoted zero tolerance of abuse and neglect of residents that it was complied with.

A) A review of the home's Prevention, Reporting and Elimination of Abuse and Neglect policy # 01-05-03 stated that when abuse or neglect is alleged to have resulted from an employee(s) action or inaction the supervisor or registered staff will meet with the employee and they will be immediately placed off work pending the investigation. August, 2014 a review of the clinical records, home's investigative notes and the Critical Incident report, submitted to the Ministry of Health dated December, 2014 was reviewed and indicated the home was notified of an allegation of resident abuse in December, 2013 around 1600 hours from a staff member. An interview with the Director of Nursing and Personal Care (DONPC) confirmed the alleged staff member continued to work the December, 2013, 1500-2300 hours evening shift on the day of the allegation.
Interview with the DONPC confirmed the manager had knowledge at the beginning of the alleged employee's shift and did not comply with the home's policy by permitting the employee to work the evening shift after knowledge of the allegation and had not ensured the home's policy was complied with by having immediately placed the employee off work pending the investigation.

B) The home's Prevention, Reporting and Elimination of Abuse and Neglect policy # 01-05-03 identified immediate reporting of any person who witnessed or has first knowledge of a suspected abuse to their manager/supervisor, or if not available , the Registered Nurse. A review of the investigative records indicated the staff member waited several days prior to reporting the witnessed verbal abuse to a member of the management team. Interview with the staff member, who witnessed and reported the alleged abuse, confirmed knowledge of the home's policy for immediate reporting and confirmed the delay in reporting was not in compliance with the home's policy. [s. 20. (1)]

Issued on this 2nd day of October, 2014

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