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
Feb 14, 2014	2013_205129_0017	H-000346-13	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

PHYLLIS HILTZ-BONTJE (129)

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): November 25, 26, December 3 and 4, 2013

During the course of the inspection, the inspector(s) spoke with Registered and unregulated nursing staff, the Director of Care and the Administrator in relation to CI Log # H-000346-13

During the course of the inspection, the inspector(s) observed residents, review clinical record documentation, reviewed investigative and interview notes made by the home, reviewed copies of letters submitted to the home, reviewed the home's policy [Prevention, Reporting and Elimination of Abuse and Neglect], as well as reviewed training information provided by the home.

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has not ensured that the written policy to promote zero tolerance of abuse and neglect of residents contains an explanation of the duty under section 24 to make mandatory reports in relation to the following: [20(2)(d)]
The homes policy [Prevention, Reporting and Elimination of Abuse and Neglect] identified as #03-13-02 and last reviewed on April 2011 does not contain an explanation of the following information identified in LTCHA 2007, S.O., c. 8, s. 24.
The written policy does not contain:
-An explanation of the requirement that a person who has reasonable ground to suspect that abuse of a resident that resulted in harm or risk of harm shall immediately report the suspicion and the information upon which it is based to the Director. The written policy does not include information for staff related to the methods of reporting this information to the Director.[24(1)2]
-An explanation of the consequences of providing information to the Director that a person knows to be false. [24(2)]
-An explanation of the reporting exceptions for residents. [24(3)]
-An explanation of the duty on practitioners and others. [24(4)]
-An explanation of the consequences related to failure to report. [24(5)]

-An explanation of the consequences related to suppressing reports. [24(7)] [s. 20. (2) (d)]

2. The licensee has not ensured that the written policy to promote zero tolerance of abuse and neglect of resident's deals with additional matters provided for in the regulations, in relation to the following: [20(2)(h)]
The homes policy [Prevention, Reporting and Elimination of Abuse and Neglect] identified as #03-13-02 and last reviewed on April 2011 does not deal with matters provided for in O. Reg. 79, s. 96(c), (e)(i)(ii) and 98. [20(2) (h)]
The home written policy to promote zero tolerance of abuse and neglect of residents does not deal with the following matters:
-The homes written policy does not identify measures and strategies to prevent abuse and neglect as required in O. Reg. 79/10, s. 96(c).
-The homes written policy does not identify training and retaining requirements including, training on the relationship between power imbalances between staff and residents, the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, as situations that may lead to abuse and neglect as well as how to avoid such situations as required in O. Reg. 79/10, s. 96(e) (i) (ii).
-The homes written policy does not explain the requirement to immediately notify the appropriate police force, under what circumstances police are required to be notified and how to determine if those circumstances exist as required in O. Reg. 79/10, s 98. [s. 20. (2) (h)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee did not ensure written letters of complaint concerning the care of residents and the operation of the home were immediately forwarded to the Director, in relation to the following: [22(1)]
The Director of Care confirmed that the home received several letter of complaint/concern from staff working on an identified home area related to the care

and treatment of residents living on that home area, but did not forward those letters to the Director.
- A letter dated April 10, 2013, identified as being received on June 10, 2013 was signed by five direct care staff working on the identified home area. This letter was also copied to the Director of Services for Seniors at the Halton Regional Office. This letter described staff concerns related to one staff and the care this staff person was providing to residents as well as concerns related to the management of the home area. The letter speaks about concern related to abuse and the way the identified staff member treated residents on the home area including: screaming at residents during care in order to have the resident abide by care instructions. The letter also identified that staff are fearful about bringing these issues forward because of the perceived power the staff person involved in the incidents has. The letter also communicated that a home area supervisor is not monitoring the care residents are receiving and does not take action to address the care being provided by the identified staff person.
-A letter dated June 13, 2013, identified as being received on June 18, 2013 submitted by a direct care staff member speaks to specific concerns related to the staff member identified in the above noted letter. This letter alleges that the staff member failed to provide care required to a resident who was unable to provide the care themselves.
-A letter dated June 17, 2013, identified as received on June 18, 2013 submitted by a direct care staff member also speaks to the care being provided by the same staff member identified above. This letter alleges this staff person was seen yelling at residents who were agitated so they would abide by care directions, concerns that this staff person was not coping with the challenges of this particular home area, that this staff member is not able to control their temper, the staff member was observed mocking residents as well as concerns related to the leadership on the home area.
-A letter dated June 16, 2013, identified as receive on June 18, 2013 submitted by a direct care staff member also speaks to the care being provided by the same staff member identified in the above three letters. This letter alleges the staff person was observed to be yelling and pointing a finger at a resident while in the tub room, observed to be scolding residents as if they were children and roughly handled a resident while attempting to assist with dressing. The letter goes on to identify another incident where an identified resident became increasing agitated when the identified staff person entered the room and made shooing motions in order to communicate that the resident wanted the staff person to leave. This complainant goes on to describe that this non-communicative resident then made motions of hitting her head which the staff person interpreted as meaning the resident had been hit by the identified staff person in the past. [s. 22. (1)]

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:

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. Five staff working in the home who had reasonable grounds to suspect that a resident had been abused did not immediately report this suspicion and the information upon which it was based to the Director, in relation to the following:
At the time of this inspection a Personal Support Worker (PSW) confirmed that a second PSW was observed on an identified date to strike resident #004 while attempting to provide care and while the resident was demonstrating responsive behaviours. The PSW who observed the incident confirmed that this was not immediately reported to the Director. Approximately 10 days following the incident the PSW who observed the incident, reported what had been observed to a Registered Practical Nurse (RPN). The RPN indicated that she directed the PSW to speak to the Manager because she suspected the resident had been abuse, but confirmed she did not report this incident to the Director. Forty days after the incident was observed the PSW who observed the incident reported to a Nurse Manager, who then reported the incident to the Director of Care and the Administrator, but did not report the incident to the Director. Three days after being made aware of the incident the Administrator notified the Director through a Critical Incident submission3. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee did not ensure that once every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences, in relation to the following: [99(b)]
The Administrator confirmed that the home annually collects statistics on incidents of abuse; however there is not an evaluation of the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect or the identification of changes or improvements that maybe required to prevent further incidents. [s. 99. (b)]

Issued on this 24th day of March, 2014

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

Phyllis Hiltz-Bontje