Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére 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
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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
Nov 18, 21, 22, 23, 30, Dec 1, 2, 6, 12, 15, 20, 22, 2011	2011_054133_0028	Critical Incident

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING EAST
400 Olive St., NORTH BAY, ON, P1B-6J4

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

CASSELLHOLME
400 OLIVE STREET, NORTH BAY, ON, P1B-6J4

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Manager of Clinical Standards, the Manager of Infection Control/Documentation, the Manager of Housekeeping & Laundry, the Human Resources Manager, a Supervisor of Nutrition and Food Services, Registered Nurses, Personal Support Workers.

During the course of the inspection, the inspector(s) reviewed the following: a critical incident report and documents related to the home's investigation into the incident, policy R7.5.0 "Reporting of Critical Incidents to MOHLTC Zero Tolerance of Abuse and Neglect" (revised September 27, 2011), policy R7.1.0 "Resident Rights: Prevention of Abuse & Neglect" (revised June 16, 2011) and the health care record of a resident. The inspector also reviewed the licensee's general orientation program for all new employees and the orientation programs for the Activity department, the Housekeeping and Laundry department, the Nutrition and Food Service department and the Clinical Services department.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Training and Orientation

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

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.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. A witnessed incident of staff to resident abuse occurred in September 2011. The abuse was perpetrated by a Personal Support Worker (PSW) and witnessed by another PSW.

A PSW was providing care to a resident. Another PSW heard yelling from the resident's bedroom and went in to find that the resident was angry and crying that they were being hurt. Despite the residents objections, the provision of care continued. The PSW providing the care was witnessed by the second PSW being rough; pushing, pulling, hitting and yelling at the resident.

The licensee's investigation into the abuse was completed in October 2011. The investigation concluded that physical and verbal abuse had occurred. The perpetrator's employment with the home was terminated.

The licensee failed to ensure that a resident's right to be protected from abuse was fully respected and promoted. [LTCHA 2007, S.O. 2007, c.8, s.3(1)2]

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 with the requirement that residents' rights to be protected from abuse are fully respected and promoted, to be implemented voluntarily.

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 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).

Findings/Faits saillants :

1. During the November 21st-23rd, 2011 inspection, the inspector was made aware of a complaint made in January 2011 by a visitor who alleged that they observed a Registered Nurse (RN) being physically abusive to a resident in January 2011. The complainant made the complaint to the Manager of Clinical Standards.

At the time of the November 21st-23rd, 2011 inspection, the Director had not been made aware of the suspected abuse. The licensee failed to ensure the Director was immediately informed of the suspected abuse of the resident. [LTCHA 2007, S.O. 2007, c.8, s.24(1)2]
2. .
An incident of staff to resident abuse occurred in September 2011.

A Personal Support Worker (PSW) witnessed the incident of staff to resident abuse as it occurred. The PSW reported the incident of abuse to a Registered Nurse (RN) on the day it occurred. A week later, the PSW reported the incident of abuse to a second RN and also filled out a "staff documentation complaint form" detailing the abuse she witnessed. Two days later, the Manager of Clinical Standards received the PSW's written report of the abuse she witnessed.

The Director was not notified of the suspected abuse until 31 days after the witnessing PSW first reported the abuse to the RN. The Director was notified via a Critical Incident Report. The licensee failed to ensure the Director was immediately informed of the suspected abuse of the resident. [LTCHA 2007, S.O. 2007, c.8, s.24(1)2]

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 with the requirement that any person who has reasonable grounds to suspect abuse of a resident by anyone shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following subsections:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff receive annual retraining in the subjects outlined in LTCHA 2007, S.O. 2007, c.8, s76(2), specifically relating to three areas: the home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports, and the protections afforded by section 26 (whistle-blowing protection)

Annual retraining is provided in the form of the annual employee performance appraisal, where staff are required to sign off that they have reviewed certain topics during the appraisal.

During the November 21st-23rd, 2011 inspection, the inspector was given policy R.7.1.0 "Residents Rights: Prevention of Abuse and Neglect" (revised June 16, 2011) and policy R7.5.0 "Reporting of Critical Incidents to MOHLTC Zero Tolerance of Abuse and Neglect" (revised September 27, 2011) to consider as the home's policy to promote zero tolerance of abuse and neglect of residents. During the annual performance appraisal, only policy R.7.1.0 is covered and not policy R7.5.0. The licensee has failed to ensure that all staff receive annual retraining relating to the home's policy to promote zero tolerance of abuse and neglect of residents. [LTCHA 2007, S.O. 2007, c.8, s. 76 (4)]

The licensee has failed to ensure that all staff receive annual retraining relating to the duty to make mandatory reports under section 24. This topic is not covered during the annual performance appraisal. This topic is addressed in policy R.7.5.0 as referenced above, yet this policy is not covered during the annual performance appraisal. [LTCHA 2007, S.O. 2007, c.8, s. 76 (4)]

The licensee has failed to ensure that all staff receive annual retraining relating to the protections afforded by section 26 (whistle-blowing protection). This topic is not covered during the annual performance appraisal. This topic is addressed in policy R.7.5.0 as referenced above, yet this policy is not covered during the annual performance appraisal. [LTCHA 2007, S.O. 2007, c.8, s. 76 (4)]

2. .

The licensee has failed to ensure that all new staff have received training in the subjects outlined in LTCHA 2007, S.O. 2007, c.8, s76(2) prior to performing their responsibilities, specifically relating to four areas: the home's policy to promote zero tolerance of abuse and neglect, the duty to make mandatory reports under section 24, the protections afforded by section 26 (whistle-blowing protection), and the Resident's Bill of Rights.

All new staff go through an orientation program specific to their own department before performing their responsibilities. During the November 21st-23rd, 2011 inspection, the inspector reviewed the orientation program for four departments.

During the November 21st-23rd, 2011 inspection, the inspector was given policy R.7.1.0 "Residents Rights: Prevention of Abuse and Neglect" (revised June 16, 2011) and policy R7.5.0 "Reporting of Critical Incidents to MOHLTC Zero Tolerance of Abuse and Neglect" (revised September 27, 2011) to consider as the home's policy to promote zero tolerance of abuse and neglect of residents. Of the four department specific orientation programs reviewed, one does not cover either policy R.7.1.0 or policy R.7.5.0, two cover policy R.7.1.0 but not policy R7.5.0 and one covers policy R.7.5.0 but not policy R7.1.0. The licensee has failed to ensure that all staff have received training relating to the home's policy to promote zero tolerance of abuse and neglect of residents before performing their responsibilities. [LTCHA 2007, S.0 2007, c.8, s. 76 (2)3].

Three of the four department specific orientation programs reviewed do not cover staff's duty to make mandatory reports under section 24. The licensee has failed to ensure that all staff receive training relating to the duty to make mandatory reports under section 24 before performing their responsibilities. [LTCHA 2007, S.O. 2007, c.8, s.76(2)4]

Of the four department specific orientation programs reviewed, none cover the topic of the protections afforded by section 26 (whistle- blowing protection). The licensee has failed to ensure that all staff receive training relating to the protections afforded by section 26 before performing their responsibilities. [LTCHA 2007, S.O 2007, c.8, s.76 (2)5]

Three of the four department specific orientation programs reviewed do not include training relating to the Residents' Bill of Rights. The licensee has failed to ensure that all staff receive training relating to the Resident's Bill of Rights before performing their responsibilities. [LTCHA 2007, S.O. 2007, c.8 s.76 (2)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 with the requirement that all new staff receive training in the areas outlined in LTCHA 2007, S.O. 2007, c.8, s.76(2) prior to performing their responsibilities and that all staff receive annual retraining in these areas, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records Specifically failed to comply with the following subsections:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. As per s.20 of LTCHA 2007, c.8, the licensee shall ensure that there is a written policy to promote zero tolerance of abuse and neglect of residents.

The inspector was given policy R.7.1.0 "Residents Rights: Prevention of Abuse & Neglect" (revised June 16, 2011) and policy R.7.5.0 "Reporting of Critical Incidents to MOHLTC Zero Tolerance of Abuse and Neglect" (revised September 27, 2011) to be considered as the licensee's written policy to promote zero tolerance of abuse and neglect of residents.

The licensee's written policy to promote zero tolerance of abuse and neglect of residents is not in compliance with all applicable requirements under the Act, specifically related to three areas: the notification of a resident's substitute decision maker and any other person specified by the resident following an incident of suspected abuse, the requirement to notify the police following any alleged, suspected or witnessed abuse or neglect of a resident and the duty of all staff to report suspicion of abuse to the Director.

As per O. Reg 79/10, s.97 (1), the resident's substitute decision-maker (SDM), if any, and any other person specified by the resident must be notified either immediately or within 12 hours upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident. The time frame for notification is dependent on the impact of the abuse.

On page 3 of 4 in Policy R7.1.0, item #7 directs the RN Supervisor who suspects resident abuse to notify the family within 12 hours of incident. This is not in compliance with O. Reg 79/10, s.97(1) because it fails to specify that it is the SDM who must be notified, does not acknowledge that there may be other persons specified by the resident who are to be notified, and does not consider the need for immediate notification. [LTCHA 2007, S.O. 2007, c.8, s.8(1)a]

On page 5 of 17 in Policy R7.5.0 under the heading "Notifications", it is stated "The substitute decision maker (SDM), if any, or any other person specified by the resident must be notified within 12 hours of becoming aware of the incident of abuse/neglect (alleged, suspected, witnessed,unwitnessed)". This is not in compliance with O. Reg 79/10, s.97(1) as it does not consider the need to notify the SDM or other persons specified by the resident immediately. [LTCHA 2007, S.O. 2007, c.8, s.8(1)a]

On page 7 of 17 in Policy R7.5.0, the fourth bullet point directs the individual who has received the report of alleged abuse or neglect to "immediately notify SDM or person requested by the resident of the incident if the resident is harmed.." This is not in compliance with O. Reg 79/10, s.97(1) because the notion of harm is not the only factor to consider when looking at the need to notify the SDM or other persons specified by the resident immediately. [LTCHA 2007, S.O. 2007, c.8, s.8(1)a]

On page 3 of 4 in Policy R7.1.0 item 8(b) states that the decision to notify the police following a report of abuse will be based upon the following: physical evidence (i.e bruising), family request, resident request. This is not in compliance with O. Reg 79/10, s.98, which indicates that the police must be notified immediately of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitutes a criminal offence. [LTCHA 2007, S.O. 2007, c.8, s.8(1)a]

On page 5 of 17 in Policy R7.5.0 under the heading "Notifications", it is stated "all incidents of physical abuse that cause physical injury, and non-consensual sexual behavior must be reported to the police and/or MOHLTC". This is not in compliance with O. Reg 79/10, s.98, which indicates that the police must be notified immediately of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitutes a criminal offence. [LTCHA 2007, S.O. 2007, c.8, s.8(1)a]

On page 3 of 4 in policy R7.1.0, the section titled "Reporting" directs the RN Supervisor to notify the Director of Clinical Services or delegate, appropriate authorities including supervisor/manager, Administrator, Board of Directors, Chair of Board of Directors and the family about suspected abuse. This is not in compliance with the LTCHA, 2007, s.24, because the Director must be notified immediately of suspected abuse and the policy does not direct the RN Supervisor to notify the Director in addition to the other persons listed. [LTCHA 2007, S.O. 2007, c.8, s.8(1)a]

On page 3 of 17 in policy R7.5.0, the section titled "Mandatory Reporting under the LTCHA" identifies that "section 24 of

the LTCHA requires certain persons, including the Home and certain staff members, to make immediate reports to the Director where there is a reasonable suspicion that certain incidents occurred or may occur". This is not in compliance with the LTCHA, 2007, s.24, because this section requires all staff members to make immediate reports to the Director. [LTCHA 2007, S.O. 2007, c.8, s.8(1)a]

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 with the requirement that the licensee's written policy to promote zero tolerance of abuse and neglect of resident is in compliance with all applicable requirements under the Act, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following subsections:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. An incident of staff to resident abuse occurred in September 2011.

A Personal Support Worker (PSW) witnessed the incident of staff to resident abuse as it occurred. The PSW reported the incident of abuse to a Registered Nurse (RN) on the day it occurred. A week later, the PSW reported the incident of abuse to a second RN and also filled out a "staff documentation complaint form" detailing the abuse they witnessed. Two days later, the Manager of Clinical Standards received the PSW's written report of the abuse they witnessed.

The licensee failed to ensure that the report to the Director was made within 10 days of becoming aware of the witnessed incident. The report was made via a Critical Incident Report and it was made to the Director 31 days after the witnessing PSW first reported the incident to the RN. [LTCHA 2007, S.O. 2007, c.8, s.104(2)]

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 with the requirement that reports about an investigation into alleged, suspected or witnessed incidents of abuse of a resident by anyone that are required under s.23(2) of the Act are made to the Director within 10 days of the licensee becoming aware of the alleged, suspected or witnessed abuse., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following subsections:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. During the November 21st-23rd, 2011 inspection, the inspector was made aware of a complaint made in January 2011 by a visitor who alleged that they observed a Registered Nurse (RN) being physically abusive to a resident in January 2011. The complainant made the complaint to the Manager of Clinical Standards.

The Director of Clinical Services conducted an investigation into this alleged abuse. The investigation was concluded in February 2011 and the allegation of abuse was not validated, however the RN was issued a verbal warning.

At the time of the November 21st-23rd, 2011 inspection, the results of the abuse investigation and the action taken in response to the alleged abuse had not been reported to the Director.

The licensee failed to ensure the results of the investigation undertaken under clause (1)(a) and the actions taken under clause (1)(b) were reported to the Director. [LTCHA 2007, S.O. 2007, c.8, s.23(2)]

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 with the requirement that every investigation undertaken under clause (1)(a) of LTCHA 2007, S.O. 2007, c.8,s.23, and every action taken under clause (1)(b) of LTCHA 2007, S.O 2007, c.8, s.23 is reported to the Director, to be implemented voluntarily.

WN #7: 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. An incident of staff to resident abuse occurred in September 2011.

A Personal Support Worker (PSW) witnessed the incident of staff to resident abuse as it occurred. The PSW reported the incident of abuse to a Registered Nurse (RN) on the day it occurred. A week later, the PSW reported the incident of abuse to a second RN and also filled out a "staff documentation complaint form" detailing the abuse she witnessed. Two days later, the Manager of Clinical Standards received the PSW's written report of the abuse they witnessed.

The licensee failed to ensure that the police force was immediately notified of the witnessed incident of abuse of the resident. At the time of the November 21st-23rd, 2011 inspection, the police force had not been notified.

WN #8: 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).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. An incident of staff to resident abuse occurred in September 2011.

A Personal Support Worker (PSW) witnessed the incident of staff to resident abuse as it occurred. The PSW reported the incident of abuse to a Registered Nurse (RN) on the day it occurred. A week later, the PSW reported the incident of abuse to a second RN and also filled out a "staff documentation complaint form" detailing the abuse she witnessed. Two days later, the Manager of Clinical Standards received the PSW's written report of the abuse they witnessed.

The licensee failed to ensure that the resident's substitute decision maker (SDM) was notified immediately upon the licensee becoming aware of the witnessed incident of abuse. At the time of the November 21st-23rd, 2011 inspection, the resident's SDM had not been made aware of the incident. [O. Reg 79/10, s.97(1)a]

2. .

The licensee's investigation into the abuse, as required under subsection 23(1) of the Act, was completed on October 25th, 2011. The investigation concluded that physical and verbal abuse had occurred. The perpetrator's employment with the home was terminated.

The licensee failed to ensure that the resident's SDM was notified of the results of the investigation immediately upon completion of the investigation. At the time of the November 21st-23rd, 2011 inspection, the resident's SDM had not been made aware of the results of the investigation. [O. Reg 79/10, s.97(2]

Issued on this 10th day of January, 2012

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

Jessica Lapensée