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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 1, 2015	2015_360111_0013	O-002140-15	Critical Incident System

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road 3rd Floor PICKERING ON L1V 1X6

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

Hope Street Terrace
20 HOPE STREET SOUTH PORT HOPE ON L1A 2M8

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

LYNDA BROWN (111)

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): May 26, 2015

A complaint (log# 002140-15) and critical incident (log # 010096-15)were both completed concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurse(RN), Personal Support Worker (PSW), and the resident.

During the course of the inspection, the inspector also reviewed a resident health record, reviewed the home's investigation, reviewed an employee record, and reviewed the home's policy on prevention of abuse and neglect.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
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. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident's right to be properly cared for in a manner consistent with his or her needs was fully respected and promoted.

Related to log # 002140 & 010096:

A critical incident report was submitted to the Director on a specified date for an "other" related to alleged staff to resident abuse. The CIR indicated two days before, at a specified time Resident #1 was observed with injuries to specified areas. The resident reported to the RN that a staff member caused the injury due to rough handling.The staff member involved in the incident reported the injury occurred while the staff was attempting to respond to the resident's responsive behaviour.

Interview and observation of Resident #1 indicated the resident had injuries to specified areas as a result of the incident and the resident stated the staff member "was too rough".

Interview of Staff #100 indicated Resident #1 can become resistive with care and sometimes aggressive but using a calm approach, joking with the resident or leaving and returning to the resident is effective in reducing behaviour.

Review of the care plan for Resident #1 indicated under Behaviour Problems-resists treatment or refuses care due to cognitive impairment. Interventions included: re-approach resident as needed and try different staff if resident initially refuses care.

Therefore, the resident's rights were not fully promoted and respected as the resident was not properly cared for according to his/her needs resulting in injury. [s. 3. (1) 4.]

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 to ensure that the residents rights to be properly cared for in a manner consistent with his or her needs 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:

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 has failed to ensure that when they had reasonable grounds to suspect that any of the following had occurred, immediately reported the suspicion and the information upon which it was based to the Director:
1.improper or incompetent treatment of care of a resident that resulted in harm or risk of harm.

A critical incident report was submitted to the Director on a specified date for an "other" related to alleged staff to resident abuse. The CIR indicated two days before, at a specified time Resident #1 was observed with injuries to specified areas. The resident reported to the RN that a staff member caused the injury due to rough handling.The staff member involved in the incident reported the injury occurred while the staff was attempting to respond to the resident's responsive behaviour.

Review of the progress notes for Resident #1 indicated on the day of the incident a staff member contacted the (acting) Administrator and was advised the (acting) Administrator "would look after it".

Interview of the Administrator indicated the Director was not contacted until the following day (when the after hours number was called). [s. 24. (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 to ensure that a person who has reasonable grounds to suspect improper or incompetent treatment or care of a resident immediately reports the suspicion upon which it is based to the Director, to be implemented voluntarily.

WN #3: 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 has failed to ensure that the appropriate police force was 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.

A critical incident report was submitted to the Director on a specified date for an "other" related to alleged staff to resident abuse. The CIR indicated two days before, at a specified time Resident #1 was observed with injuries to specified areas. The resident reported to the RN that a staff member caused the injury due to rough handling.The staff member involved in the incident reported the injury occurred while the staff was attempting to respond to the resident's responsive behaviour.

Review of the homes investigation and interview of the (acting)Administrator indicated the police were not called until the following day. [s. 98.]

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 to ensure 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that criminal reference checks are conducted prior to hiring the staff member and/or accepted volunteer who is 18 years of age or older.

Review of an employee file had no record of a police check completed prior (or post) hire. [s. 75. (2)]

Issued on this 1st day of June, 2015

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

Original report signed by the inspector.