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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 24, 2018	2018_615609_0023	021031-17, 006076-18, 006428-18, 008948-18, 012456-18, 012508-18, 015234-18	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the City of Timmins
481 Melrose Blvd. TIMMINS ON P4N 5H3

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

Golden Manor
481 Melrose Boulevard TIMMINS ON P4N 5H3

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

CHAD CAMPS (609)

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): October 15-19, 2018.

The following intakes were completed during this Critical Incident System (CIS) inspection:

Two intakes related to resident falls;
Two intakes related to infectious outbreaks;
Two intakes related to resident behaviours; and
One intake related to staff to resident abuse.

A Complaint inspection #2018_615609_0022 was conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Dietitian (RD), Administrative Assistant (AA), Registered Nurses (RNs), Personal Support Workers (PSWs) and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, as well as numerous licensee policies, procedures and programs.

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

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
2 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

a) A Critical Incident (CI) report was submitted by the home to the Director which outlined how resident #004 was found on the floor, complaining of pain. They were transferred to the hospital and diagnosed with an injury.

Inspector #609 reviewed resident #004's "MORSE" Fall Scale which indicated that the resident was at very high risk of falls.

A review of resident #004's plan of care at the time of the fall indicated that they required a specific intervention be completed to ensure the resident's safety.

During an interview with PSW #107, they verified that resident #004 required the specified intervention, as outlined in the plan of care and that this should have been documented on a particular tool.

During an interview with RN #106, they were unable to locate any documentation to indicate that resident #004's specified intervention was being completed.

b) Inspector #609 reviewed a CI report submitted by the home to the Director which described how resident #005 fell, was transferred to the hospital and diagnosed with an injury.

The "MORSE" Fall Scale completed prior to the fall indicated resident #005 was at very high risk of falls.

A review of resident #004's plan of care indicated that they required a specific intervention be completed to ensure the resident's safety.

During an interview with PSW #107, they described how the specified intervention was documented on a particular tool.

A review of the home's policy titled "Resident Care Planning" no revision date required all care provided be documented in accordance with what was set out in the plan of care.

During an interview with the DOC, they described how the specified intervention required for resident #004 and #005 was to be documented on a particular tool. The DOC was unable to provide any documentation to verify that either resident #004's or resident #005's specified intervention was completed as outlined in their plans of care. [s. 6. (9) 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 the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

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 the home’s written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A Critical Incident (CI) report was submitted by the home to the Director which alleged that PSW #100 did not provide specific care required by resident #003 on a particular day. The CI report further alleged that despite being informed that the resident required the specified care by PSW #101, PSW #100 knowingly left resident #003 for a prolonged period of time without providing the specified care.

During an interview with PSW #101, they described how on a particular day they were made aware that resident #003 required specified care which they then passed along to PSW #100 who was the resident’s primary PSW.

After a prolonged period of time, PSW #101 attended resident #003 who rang for assistance. The PSW indicated that the resident was found in an unclean state. PSW #100 stated to PSW #101 that they hoped the resident would have forgotten they called for help and verified they had not provided any of the specified care to the resident.

A review of the home’s policy titled “Zero Tolerance of Abuse and Neglect” no revision indicated that the home was committed to a zero tolerance of abuse or neglect of its residents.

During an interview with the DOC, they verified that PSW #100 was found to have neglected resident #003 when they left the resident for a prolonged period of time without providing them with the specified care they required.

A review of PSW #100’s letter of correction outlined how as a result of the home’s internal investigation into allegations of neglect of resident #003, PSW #100 received disciplinary action. [s. 20. (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 the home's written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

Issued on this 1st day of November, 2018

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

Original report signed by the inspector.