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

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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
Mar 7, 2014	2014_049143_0007	O-000774-13, O-000940-13	Complaint

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF NORTHUMBERLAND
983 Burnham Street, COBOURG, ON, K9A-5J6

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

GOLDEN PLOUGH LODGE
983 BURNHAM STREET, COBOURG, ON, K9A-5J6

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

PAUL MILLER (143)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 6th and 7th, 2014.

A Critical Incident Inspection Log # O-00940-13 was also completed during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, two Assistant Directors of Care, a Personal Support Worker, residents and family members.

During the course of the inspection, the inspector(s) reviewed resident health care records, attendance records, abuse policies and procedures, abuse training materials, internal abuse investigation reports and observed resident care and services.

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. 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:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The following finding is related to Log #O-000774-13:

Ontario Regulation 79/10 section 2. (1) For the purposes of the definition of "abuse" in subsection 2(1) of the Act,

"emotional abuse" means, (a) any threatening, insulting, intimidating or humiliating gestures, actions, behavior or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident

"verbal abuse" means, (a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident,

"physical abuse" means, subject to subsection (2),
(a) the use of physical force by anyone other than a resident that causes physical injury or pain,
(2) For the purpose of clause (a) of the definition of "physical abuse" in subsection (1), physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances.

On a specified date and time a family member (complainant) observed a staff member (S103) pushing a snack cart in the hallway of a resident home area (RHA). Resident #2 was observed requesting that S103 provide her/him a bath. S103 was observed by the family member yelling at the resident "you didn't want a bath in the morning and you are not getting one now". The resident continued in her/his request to have a bath and then the family member observed S103 scream at the resident that a bath was not going to be provided. The family member observed the staff member to be red faced, using an angry loud voice with a demeaning tone and manner directed at Resident #2. The resident was observed by the family member to be trembling and tearing up in her/his eyes. The family member reported that this occurred over approximately one minute and that the staff member walked away from the resident leaving the resident in an upset agitated state. [s. 3. (1) 2.]

2. The following finding is related to Log #O-000940-13:

On a specified date S100 reported allegations of abuse by staff members. The Licensee hired an external human resource consultant to complete an internal abuse investigation. S100 reported observing S109 forcefully removing Resident #1's clothing, throwing the resident into bed, swearing and using an aggressive manner while providing care to the resident. This staff member was also observed making

derogatory comments and swearing in front of Resident #4.

S107 reported observing S109 providing care to Resident #1. S107 reported that S109 spoke with a loud voice and negative tone towards Resident #1 stating "for Gods sakes stand up". S107 reported that S109 was forceful in the care she/he provided to Resident #1.

The internal investigation indicated that S105 had been observed by S100 yelling at Resident #3, using derogatory comments and belittling the resident with comments such as "you are a filthy woman/man, you are disgusting and your mother would be disgusted with you". S105 was also observed transferring the resident and striking out at Resident #3 in an aggressive manner hitting the resident in the shoulder area.

S107 reported that S105's attitude towards residents is "really bad". S107 described S105 as being short with residents and uses an angry and condescending tone while providing resident care.

The internal investigation concluded that there was sufficient evidence to support that S109 and S105 had abused residents. Progressive disciplinary action was taken by the Licensee in respect of S105 and S109.

The licensee has failed to comply with the Long Term Care Homes Act section 3.(1) (2) by failing to ensure that residents are protected from abuse. [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 to ensure that residents are free from abuse and that staff are trained in abuse recognition, abuse prevention and mandatory abuse reporting requirements, 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 following finding is related to Log #O-000940-13:

On a specified date S100 reported to management staff allegations of physical, verbal and emotional abuse involving residents. The alleged abuse took place over a specified period of time.
The home commenced an internal investigation into allegations of abuse. During these investigations another staff member S107 reported that she/he had witnessed S109 being rough with Resident #1 and using a loud voice with a negative tone towards Resident #1.
S107 reported that she/he had observed S105 using short, angry, and a condescending tone towards residents. S107 reported that S105's attitude is really bad towards residents.
S100 and S107 reported that these incidents of abuse had occurred over a specified period and time.

The internal investigation concluded that given the serious nature of what S107 and S100 had witnessed that they were both negligent in their duties to report abuse. Progressive disciplinary action was taken by the Licensee in respect of S100 and S107.

S100 and S107 have failed to comply with the Long Term Care Homes Act section 24. (1)2. by not immediately reporting abuse of a resident. [s. 24. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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. The following findings are in respect of Log # O-000940-13:
On a specified date S100 provided in writing allegations of physical, verbal and emotional abuse involving residents.
S100 indicated that Resident #1 was physically abused by S109 who forcefully removed her/his clothes, threw her/him into bed and swore at the resident (verbal abuse Golden Plough Lodge Policy No.:EC18-01 page 10 of 18)
On a specified date Resident #1 substitute decision maker (SDM) and power of attorney for personal care was contacted by an Assistant Director of Care S108 and advised of "misappropriate staff conduct" and the home was investigating the incident.
On a specified date an independent human resource consultant (hired by Northumberland County) began an investigation into reported allegations of abuse. A completed investigation report was submitted to Northumberland County on a specified date.
Resident #1's SDM was contacted by S108 three weeks following the completed abuse investigation and advised that the investigation into allegations of inappropriate staff conduct was completed and that the home could not share any details for confidentiality reasons. The SDM was advised that staff involved have been dealt with appropriately.
On February 5th, 2013 during a telephone interview with Resident #1's SDM the inspector was informed that at no time had the home reported to him/her the results of the alleged abuse investigation.
On February 7th, 2014 the DOC and the two ADOC's confirmed with the inspector that the SDM had not been informed of the results of the abuse investigation that was completed.

The licensee has failed to comply with Ontario Regulation 79/10 section 97.(2) by not immediately informing the SDM of the results of the abuse investigation. [s. 97. (2)]

Issued on this 7th day of March, 2014

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

Paul Miller