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
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
130 Dufferin Avenue, 4th floor
LONDON, ON, N6A-5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin, 4ème étage
LONDON, ON, N6A-5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 12, 2014	2014_303563_0030	002091-14	Critical Incident System

Licensee/Titulaire de permis

GOLDEN YEARS NURSING HOMES (CAMBRIDGE) INC
704 EAGLE STREET NORTH, P.O. BOX 3277, CAMBRIDGE, ON, N3H-4T3

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

GOLDEN YEARS NURSING HOME
704 EAGLE STREET NORTH, P.O. BOX 3277, CAMBRIDGE, ON, N3H-4T3

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

MELANIE NORTHEY (563)

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): September 8, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, one Registered Practical Nurse and one Resident.

During the course of the inspection, the inspector(s) made observations, reviewed the home's investigation notes, health records, education records, policies and other relevant documentation.

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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 O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Record review of the "Intruder" Policy, reference # 011020.00 effective November 1, 2011 revealed the procedure included that "The nursing staff will ensure that all visitors sign in or out" and "Anyone unfamiliar or found loitering in the home, will be approached by staff in a non-confrontation and professional manner" and “Once the nature of the visit has been determined, advise the visitor it is the policy of the home that all visiting persons register at the reception desk. If they have not registered at reception, ask them to return to reception to register. If the person demonstrates an unwillingness to cooperate advise them that the home will call the police upon refusal to comply." "If an unauthorized individual is not recognized, has no purpose for being in the home, or look suspicious, advise the nearest Supervisor or management staff member so they can initiate CODE PURPLE."

Record review of the home’s investigation notes following the alleged abuse of a resident by a visitor to the home revealed two of the three staff members interviewed shared that an unfamiliar person was “walking around the home” and staff “had not seen him before.”

The Administrator confirmed it is the home’s expectation to follow all policies put in place and that there is not a sign in and out book for visitors as stated in the “Intruder” policy. The Administrator shared that a sign in/out register will be put into effect immediately and all staff will review this policy. [s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #2: 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:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident listing names of all residents involved.

Record review of the Critical Incident Report revealed Resident #002 was absent under the "Identifying Information" section where by the name of residents involved in the unusual occurrence are identified. No other section of the Critical Incident Report mentions Resident #002 or that the unfamiliar individual suspected of abuse came into contact with anyone other than Resident #001.

The Administrator confirmed Resident #002 was overlooked during the investigation. The Administrator confirmed the Critical Incident Report should have been updated to include Resident #002 and the appropriate actions taken in response to the incident documented. [s. 104. (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 the report to the Director included the following description of the individuals involved in the incident listing names of all residents involved, to be implemented voluntarily.

Issued on this 12th day of September, 2014

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