Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 28, 2020	2020_795735_0004	001357-20	Complaint

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

KRISTAL PITTER (735)

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 18-21, and 24, 2020.

The following intake was completed in this Complaint inspection:

Log # 001357-20 related to personal support services.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Assistant Director of Care (ADOC), the Director of Resident Quality Outcomes (DRQO), the Director of Food Services (DFS), a Registered Nurse (RN), a Registered Practical Nurse (RPN), Personal Support Workers (PSWs), and residents.

The inspector also toured the resident home areas, observed resident care provision, resident staff interaction, dining services, and reviewed relevant resident clinical records, and policies and procedures pertaining to the inspection.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 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	Légende 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident System (CIS) Report was submitted to the Ministry of Long-Term Care (MLTC) that reported alleged staff to resident neglect. The CIS Report documented that resident #001 was left unattended during a specific activity of daily living without a call bell, and staff didn't return for approximately 45 minutes. Resident #001 was not harmed from the incident.

A complaint regarding the same incident was also submitted to the MLTC Action Line.

Both resident #001 and PSW #102 reported that the resident preferred specific care related to an activity of daily living.

Review of resident #001's plan of care that was in effect on the date of the incident, showed that resident #001 preferred specific care during an activity of daily living, and required staff assistance to complete that activity.

Director of Care (DOC) #100 acknowledged that the care provided was not in accordance with resident #001's plan of care.

The licensee failed to ensure that care was provided to resident #001 as specified in the plan of care. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents.

A CIS Report was submitted to the MLTC that reported alleged staff to resident neglect. The CIS Report documented that resident #001 was left unattended during a specific activity of daily living without a call bell, and staff didn't return for approximately 45 minutes. Resident #001 was not harmed from the incident.

The home's Complaint Record Form and resident #001 reported that the resident was left unattended during a specific activity of daily living without a call bell within reach for what seemed to be over 30 minutes.

ADOC #105 reported that the call bells were not functioning on resident #001's home area on the date of the incident.

DOC #100 reported that although temporary desk bells were available for use in the home, staff did not provide resident #001 with a desk bell.

The licensee has failed to ensure that a resident-staff communication and response system, call bell, was easily seen, accessed, and used by resident #001. [s. 17. (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 to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed, and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #3: 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.
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, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that neglect of a resident had occurred or may have occurred immediately reported the suspicion and the information upon which it was based to the Director.

A CIS Report was submitted to the MLTC that reported alleged staff to resident neglect. No call was made to the MLTC after hours pager.

The home's Complaint Record Form documented that the home's former Executive Director (ED) was advised of this incident by resident #001.

DOC #100 stated that the home knew about this incident, and acknowledged that the home did not submit the CIS Report to the MLTC until three days later. DOC #100 confirmed that the expectation was that all incidents of suspected or witnessed abuse or neglect of a resident were to be reported to the MLTC immediately and indicated the home should have reported the incident to the Director immediately.

In reference to LTCHA, 2007, s. 152 (2), all staff are required to report alleged or witnessed abuse and neglect and the licensee is responsible for all staff.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that neglect of resident #001, which resulted in a risk of harm, was immediately reported with the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

Issued on this 28th day of February, 2020

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

Original report signed by the inspector.