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
Dec 13, 2013	2013_128138_0045	O-000996-13 O-000997-13	Critical Incident System

Licensee/Titulaire de permis

GEM HEALTH CARE GROUP LIMITED
470 RAGLAN STREET NORTH, RENFREW, ON, K7V-1P5

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

GROVES PARK LODGE
470 RAGLAN STREET NORTH, RENFREW, ON, K7V-1P5

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

PAULA MACDONALD (138)

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): December 9 and 10, 2013

During the course of the inspection, the inspector(s) spoke with residents, the Clinical Supervisor, the Administrator, a Behavioural Support Ontario team member, the President of the Residents' Council, and a registered practical nurse.

During the course of the inspection, the inspector(s) reviewed two Critical Incident Reports, reviewed Resident Satisfaction Survey for 2011 and 2012, reviewed staff training of prevention of abuse, reviewed the abuse policy as well as the policy on resident to resident incidents of violence, reviewed several resident health care records, and observed staff to resident interactions

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

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 S.O 2007, c.8, s. 20. (2) (d) and (h) in that the licensee failed to ensure that its written policy to promote zero tolerance of abuse and neglect of residents contains an explanation of the duty under section 24 to make mandatory reports and failed to ensure that the policy shall deal with any additional matters as may be provided for in the regulations.

Long Term Care Home (LTCH) Inspector #138 was provided a copy of the home's abuse policy (Abuse, revised June 2011) by the Administrator. LTCH Inspector reviewed the policy and noted that the section relating to reporting to the Ministry was not consistent with current legislation.

Specifically, the home's policy stated that the Operator of the home will notify the Ministry Regional Office within 24 hours of having determined that abuse may have taken place, has taken place, or is likely to take place. This is not consistent with the Long Term Care Homes Act (LTCHA) 2007 section 24. which states a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

In addition, the home's abuse policy relating to the reporting of completed investigations was also not consistent with the legislation. The home's policy on abuse stated that the Operator will complete the investigation of any reported abuse within one month and forward the final report to the Regional Offices within the one month. Conversely, Ontario Regulation 79/10 section 104., subsection (2) and (3) states that the licensee shall make a report within 10 days of becoming aware of the alleged, suspected, witnessed incident, or at an earlier date if required by the Director and that if not everything required can be provided in the report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. [s. 20. (2)]

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 failed to comply with LTCHA, 2007 S.O 2007, c.8, s. 24. (1) 2. in that the licensee failed to ensure that a person who has reasonable grounds to suspect that any abuse of a resident by anyone that resulted in harm or a risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director.

The Director received two Critical Incident Reports outlining resident to resident abuse. The first Critical Incident Report outlined an incident of resident to resident abuse witnessed by staff in which a resident struck another resident several times resulting in pain as well as an injury. The incident occurred on a date in October 2013 but was not reported immediately to the Director and instead was reported four days later.

The second Critical Incident Report outlined another incident of resident to resident abuse that was responded to by staff. In this incident, a resident injured another resident on a date in October 2013. The Director was not informed immediately but instead was informed four days later. [s. 24. (1)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 S.O 2007, c. 8. s. 76. (4) in that the licensee failed to shall ensure that the persons who receive training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulation.

In accordance with LTCHA 2007 section 76. (2) 3., 76. (4) and Ontario Regulation 79/10 section 219. (1) the licensee shall ensure that all staff at the home received training as required on the long term care home's policy to promote zero tolerance of abuse and neglect of residents and that all persons who received this training receive retraining annually.

LTCH Inspector #138 reviewed the home's annual training relating to abuse with the Clinical Supervisor. The Clinical Supervisor was able to demonstrate that the home provides annual training on abuse however the annual training did not include the home's policy to promote zero tolerance of abuse and neglect of residents. The Clinical Supervisor stated that the home's policy to promote zero tolerance of abuse and neglect of residents was available for reference to staff but that it was not included in the annual training. [s. 76. (4)]

WN #4: 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 failed to comply with O. Reg 79/10 s. 98 in that the licensee failed to 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 criminal offense.

LTCH Inspector #138 reviewed a Critical Incident Report that outlined resident to resident abuse in which a resident repeatedly struck another resident causing pain and an injury to the other resident. The resident who was struck and injured was interviewed by the LTCH Inspector. The resident stated that the attack was sudden and unexpected, that the resident repeatedly stuck him/her and then caused an injury when s/he tried to defend himself/herself. The Critical Incident Report did not indicate if the police was notified but the Administrator stated that the police were not notified of this incident.

Discussion was held with the Clinical Supervisor regarding the home's process for notifying police for incidents of resident abuse. The Clinical Supervisor stated that police are called at the resident's wishes, if the home requires physical assistance to separate individuals, or at the registered nurses' discretion. Further discussion was held with the Administrator who stated that the police are contacted at the request of the resident and, in this incident, the resident did not wish for the police to be notified. [s. 98.]

Issued on this 13th day of December, 2013

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

Paula MacDonald RP