Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 4, 6, 20, 21, 24, 28, Nov 2, 3, 4, 2011	2011_048175_0015	Critical Incident

Licensee/Titulaire de permis

REGIONAL MUNICIPALITY OF DURHAM
605 Rossland Road East, WHITBY, ON, L1N-6A3

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

LAKEVIEW MANOR
133 Main Street, P.O. Box 514, Beaverton, ON, L0K-1A0

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

BRENDA THOMPSON (175)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with Administrator (ADM), Director of Care(DOC), Resident Care Co-ordinator (RCC), Registered Nurses, (RN), Registered Practical Nurses (RPN), Personal support Worker (PSW), Health Care Aide (HCA), Resident

During the course of the inspection, the inspector(s) reviewed Critical Incident Report, Resident Abuse Allegation Report including Witness Statements of resident, Registered nurses, Practical Nurses, PSW, Health Care Aide (HCA), reviewed Health Care Record of identified resident specifically related to the incident, the home's Abuse & Neglect-Reporting & Investigation & Prevention Policies , Lakeview Manor Home Management Meeting Minutes.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

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 subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. (Ref 3(1)1)
Verbal Report to Ministry of Health and Long Term Care from the home, when an identified, capable resident, initially reported that an incident occurred with an identified staff member. The resident reported not feeling respected or treated as an adult by the accused staff member.

2.A second report was made by the resident to another staff member.
The second staff member then asked the resident if the resident was sure the accused staff member wasn't just expressing safety concerns. The resident agreed, however, stated the staff member made the resident feel less than an adult and embarassed in front of other staff members.

3.Written statement of accused staff member indicated the staff member told the resident of not being aware of the resident's current care plan, nor was another of the staff members in the room aware of the resident's current care plan.

4.Written statement of one of the witnesses indicated the accused staff member did not treat the resident with respect or as an adult and the resident was upset by these actions.

5.An investigation of alleged staff:resident verbal and psychological/emotional abuse was conducted by the home. The conclusion of the investigation was "allegation of abuse inconclusive."

6.The home's Policy and Procedure Abuse & Neglect-Prevention, indicates that the Long Term Care (LTC) Division of the Region of Durham recognizes and supports the right of every resident living in the Region of Durham's Long Term Care Homes to live in a safe environment free from abuse and neglect and to be treated with dignity and unconditional positive regard. Resident's rights are to be respected at all times and in all circumstances.

7.The licensee did not ensure that rights of residents are fully respected and promoted- The documented statements of staff indicated that the resident did not feel respected or treated as an adult, was berated and belittled in front of two other staff. The home's conclusion that the resident's allegation of verbal and psycho/emotional abuse was "inconclusive" when in fact, the home's findings align with the home's definition of abuse, does not acknowledge the resident as a individual, worthy of being treated with dignity and respect.

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 the following rights of residents are fully respected and promoted "every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #2: 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 subsections:

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. Resident Care Plan indicates:
Staff will support identified resident's desire to be involved in care, while ensuring safety.
Total assistance of two staff,
Identified resident has been safety checked by identified staff member to participate directly in specific care. This is important to the identified resident's sense of involvement in care.

The identified resident participates directly in specific care. The identified resident has been assessed as as capable to do so...,

2. Accused staff member statement of events from incident:
"There has been an updated care plan or portions of it included in report with instructions to review every day at report but this did not include the changes and agreement that the identified resident may participate directly in specific care and the information was never passed on to me verbally, since that change either.
The identified resident said to writer and other staff that the identified resident is allowed to participate directly in specific care, stating 'it's in my care plan". I (staff member)acknowledged that it was information I was not aware of...One of the other staff looking after the identified resident, was also not aware of this.

3. Second staff member's resident progress notes indicated the identified resident, was obviously agitated regarding the incident. The staff member told me that I was not allowed to participate directly in specific care... and besides I am allowed to do that...I told the resident I did not know that also...

4.The licensee did not ensure that the staff, providing care to the identified resident, were kept aware of the contents of the resident's plan of care.

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 staff and others who provide direct care to the resident are kept aware of the contents of the resident's plan of care, to be implemented voluntarily.

WN #3: 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 subsections:

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. Verbal Report to Ministry of Health and Long Term Care, that a resident reported a staff member was not treating the resident with respect, or as an adult.

2. A second report of the incident, was made by the resident, to another registered nursing staff member.The resident was asked if the resident was sure the accused accused staff member was not just expressing safety concerns.

3. Written statement of accused staff member indicated that the accused staff member made a belittling remark to the resident in front of two other staff members.

4.An investigation of alleged staff:resident verbal and psychological/emotional abuse was conducted by the home. The conclusion of the investigation was "allegation of abuse inconclusive."

5.The home's Abuse & Neglect-Reporting and Investigation Policy defines Psychological/Emotional Abuse of a resident "is any action or behaviour that may diminish the sense of identity, dignity or self-worth of a resident..Verbal abuse of a resident "is any form of verbal communication of a belittling or degrading nature which may diminish the resident's sense of well-being, dignity or self-worth..."

6.The home's Policy and Procedure Abuse & Neglect-Prevention, indicates that the Long Term Care (LTC) Division of the Region of Durham recognizes and supports the right of every resident living in the Region of Durham's Long Term Care Homes to live in a safe environment free from abuse and neglect and to be treated with dignity and unconditional positive regard. Resident's rights are to be respected at all times and in all circumstances.

The home did not comply with their Abuse Policies & Procedures to promote zero tolerance of abuse. The home failed to acknowledge the identified resident's repeated statements of feelings of not being respected or treated as an adult, berated and embarrassed by an identified staff member in front of others, diminishing feelings of the resident's self worth. The findings of the home's investigation of alleged staff to resident verbal and psychological abuse aligned with the definitions as outlined in the home's Abuse Policies & Procedures, however, the conclusion, deemed by the home to be "inconclusive for abuse" did not demonstrate that the home's Abuse Policies were applied by the person conducting the investigation.

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 policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

Issued on this 22nd day of November, 2011

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