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 14, 2014	2014_226192_0005	L-000071-14, L-000092-14	Critical Incident System

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

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

THE VILLAGE OF RIVERSIDE GLEN
60 WOODLAWN ROAD EAST, GUELPH, ON, N1H-8M8

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

DEBORA SAVILLE (192)

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): February 19, 20, 2014

This inspection was completed concurrently with inspection 2014_226192_0003 (L-000045-14); 2014_226192_0006 (L-000041-14) and 2014_202165_0005 (L-000126-14).
Inspector Christine McCarthy participated in collection of information related to this inspection.

During the course of the inspection, the inspector(s) spoke with the Assistant General Manager, Acting Director of Care, Assistant Director of Care, Pushlinch Neighborhood Coordinator, Personal Support Workers and residents.

During the course of the inspection, the inspector(s) reviewed medical records, incident investigation notes, policy and procedure and education records.

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect resident #001 from abuse by anyone and free from neglect by the licensee or staff in the home.

Record review and interview confirm that on a specified date in 2014 resident #001 was abused by a staff member of the home.

Documentation review identified that the resident was calling out during the night shift in 2014, which was an indicator that the resident required assistance. The identified staff member went to the resident's room to provide care. Shortly after the staff member entered resident #001's room the identified staff member was overheard by co-workers to be yelling profanities at the resident, telling them they could scream all night and refusing to provide care. The identified staff member then left the resident without having provided care.

During the course of the home's investigation into this incident of verbal abuse directed at resident #001, the home identified that a staff member had overheard a similar incident of abuse directed at resident #001 on a specified date in 2013.

A review of the home's investigation notes and interview identified that this employee had also been disciplined related to an incident of refusing to provide care to resident #001 earlier in 2013.

The home failed to protect resident #001 from abuse and neglect by an identified Personal Support Worker who routinely provided the resident care. [s. 19. (1)]

2. The licensee failed to protect resident #002 from abuse by anyone and free from neglect by the licensee or staff of the home.

A) Resident #002 requested assistance on a specified date in 2014. Record review and interview confirm that the resident's request for assistance was refused by staff for a period of one hour and twenty minutes.

The plan of care identified that resident #002 was able to communicate their needs to staff. Resident #002 was also identified in the plan of care to be at risk of altered skin integrity and under Impaired Skin Integrity indicated that wet incontinence pads should be changed immediately and skin kept clean and dry.

B) Record review and interview confirm that on the specified date in 2014, specified staff spoke to resident #002 in a manner that was abusive, stating "you better not start any of your crap 'cause I'm not in the mood tonight". This resulted in an emotional response from the resident. The staff member then refused to provide the resident the requested care.

C) Record review and interview confirm that on the specified date in 2014 resident #002 who has a specified diagnosis, was demonstrating behaviours known to staff of the home. In response to a comment from resident #002 staff replied "really, I would love to see that, get up and walk." Care was not provided to the resident by this staff member.

Resident #002 was subjected to verbal abuse that resulted in an exacerbation of their behaviours and care required by the resident was withheld. [s. 19. (1)]

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 protecting residents from abuse by anyone and shall ensure resident are not neglected by the licensee or staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

Resident #001 was verbally abused in 2014 by a staff member of the home. An investigation into the incident of abuse was initiated immediately and had been completed.
Interview and record review confirm that the results of the abuse and neglect investigation were not reported to the Director. [s. 23. (2)]

2. In 2014 resident #002 was verbally abused and the resident was neglected. The home completed an investigation and reported the incident to the Director 6 days following the incident.

Interview and record review confirm that the results of the investigation into the allegation of abuse were not reported to the Director.

Critical Incident report 2915-00010-14 inspected under inspection 2014_202165_0005 was confirmed by documentation review and interview to have been investigated by the home, however no results from the investigation were reported to the Director. [s. 23. (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 ensuring that the results of every investigation related to abuse or neglect is reported to the Director, 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. 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. Any person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director.

Resident #001 was observed to have been verbally abused and refused the provision of care in 2014. The licensee was made aware of the incident and acted to protect the resident by removing the employee from the home area. The incident of alleged abuse, known to the licensee on a specified date in 2014 was not reported to the Director for approximately 36 hours.

During the course of the homes investigation of the 2014 incident of verbal abuse directed at resident #001, it was identified that a similar incident of verbal abuse was witnessed by a staff member in 2013. In 2013, the same Personal Support Worker was allegedly overheard verbally abusing resident #001. This alleged incident of abuse was not reported to the Director at the time of the incident or at the time it was brought to the home's attention in 2014.

The Director was not notified of an incident of verbal abuse in 2014 and an allegation of verbal abuse that occurred in 2013. [s. 24. (1)]

2. It was alleged that resident #002 was verbally abused and their care was neglected by staff working on a specified date in 2014. The alleged incident of abuse was reported to the Director through the Critical Incident System (CIS) thirteen days following the incident.

The licensee failed to report the alleged incident of abuse and neglect directed toward resident #002 to the Director, immediately as required. [s. 24. (1)]

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 ensuring that any person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #4: 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. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Resident #001 was observed to have been verbally abused in 2014 by a staff member of the home.

Interview confirmed that the SDM was not notified by the Neighborhood Coordinator, that the SDM would be notified as the resident is incapable and that if the SDM had been notified, it would be documented in the progress notes on the medical record. The medical record was reviewed for the period following the incident and does not contain record of the SDM having been notified of the verbal abuse that occurred in 2014. [s. 97. (1) (b)]

Issued on this 14th day of March, 2014

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

Debora Saville (192)