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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 16, 2015	2015_168202_0009	T-1470-14	Critical Incident System

Licensee/Titulaire de permis

VICTORIA VILLAGE INC.
76 ROSS STREET BARRIE ON L4N 1G3

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

VICTORIA VILLAGE MANOR
78 ROSS STREET BARRIE ON L4N 1G3

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

VALERIE JOHNSTON (202)

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): June 08, 09,10, 11, 12, 15, 16, 17, 18, 19, 2015.

During the course of the inspection, the inspector(s) spoke with the director of care, assistant director of care, rai coordinator, director of resident and family services, physiotherapy assistant, registered nursing staff, personal support workers, residents.

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

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	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an assessment of the resident and the resident's needs and preferences.

An interview with the RAI-coordinator indicated that on an identified date, when providing care to resident #01, the resident verbalized that he/she wanted a change of care givers. The resident requested that an identified PSW not provide his/her care anymore. The RAI-coordinator indicated that after the resident voiced his/her care giving preference, he/she reported the resident’s preference to an identified RPN.

An interview with the RPN indicated that he/she informed the identified PSW not to provide care to the resident and assigned the resident to the PSW working a shorter shift. The RPN indicated that the PSW working the shorter shift, would have enough time to provide the resident with morning care and for the rest of the day, the identified PSW would remain assigned to the resident. The RPN indicated that the identified PSW had been observed to provide care to the resident after the date he/she had been informed.

A review of resident #01's clinical records and interview with the RPN indicated that on a proceeding identified date the resident was observed to be upset. The resident again requested that the identified PSW not provide him/her with care. The RPN indicated in an interview that the identified PSW was informed again not to provide the resident with care. The RPN confirmed, however, that there were no directions to staff or changes made to the resident’s plan of care to reflect his/her staffing preference.

An interview with the identified PSW indicated that he/she continued to provide care to resident #01 from the the initial request and until the resident alleged that the PSW had physically abused him/her during care. The PSW indicated that while he/she continued to be assigned to resident #01, it was challenging to find a staff member to switch residents with in order to satisfy the resident's preference. Other staff were interviewed assigned to the resident's identified home area, revealed a lack of knowledge that resident #01 had a staff preference.
Interviews with both the RPN and the ADOC confirmed that the resident's preference to not have the identified PSW provide him/her care had not been included in the resident's plan of care or implemented between the identified time period. [s. 6. (2)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

An interview with the RAI-coordinator indicated that on an identified date, resident #01 requested that an identified PSW not provide his/her care anymore.

An interview with an identified registered staff member indicated that he/she informed the PSW not to provide care to the resident and assigned the resident's care to the PSW working a shorter shift. The registered staff indicated that the shorter shift works four hours per day, allowing the staff member working the short shift enough time to provide the resident with morning care.

A review of resident #01's clinical records and interview with the identified registered staff indicated that on an identified date, the resident was upset. The resident requested again that the identified PSW not provide him/her with care anymore. The registered staff indicated that the PSW had been directed to not provide care to the resident. The RPN indicated that despite the resident's request that the PSW not provide the resident with care, the PSW continued to do so.

PSW #01 indicated in an interview awareness that the resident did not want him/her providing his/her care, however, felt that he/she needed to do so on a few occasions as it was difficult finding staff to switch assignments and the short shift left early. Other staff were interviewed and indicated no awareness of PSW #01's restrictions.

On an identified date, resident #01 reported to an identified RN, that an identified PSW had physically abused him/her during care. Three days later on a subsequent date, the ADOC confirmed in an interview receipt of the above allegation and it was on this day that the ADOC learned of the resident's previous requests of not having the PSW provide him/her care. The ADOC indicated that there were no findings to support that the PSW had physically abused the resident, following the investigation, however, the identified PSW was disciplined continually providing care to the resident after being asked not to.

The ADOC indicated that only at the time of the investigation did he/she learn that resident #01 did not want the identified PSW providing his/her care. The ADOC indicated that there had been no collaboration among the multidisciplinary team in the development and implementation of resident #01's plan of care with respect to his/her preferences. [s. 6. (4) (b)]

3. An interview with an identified registered staff indicated that on an identified date, the Power of Attorney (POA) of resident #03 reported that he/she had concerns of an identified PSW providing his/her mother/father care. The registered staff indicated that at the time at which the concerns were brought forward, the identified PSW had been informed not to provide care to resident #03, and the resident was assigned to another PSW. An interview with an identified registered staff indicated that the identified PSW continued to provide care to the resident after receiving the request of the family because the resident really liked the identified PSW.

An interview with PSW #01 indicated that he/she was aware not to provide care to the resident, however, continued to do so because it was difficult to find another staff member to switch resident's with. An interview with the ADOC indicated that the POA brought his/her concerns forward on the above identified date, and had not been notified of the POA's concerns prior to this. Staff interviews revealed a lack of awareness of the identified PSW's restriction to provide resident #03 care. The ADOC and registered staff indicated in interviews that changes should have been made to the resident's plan of care after the POA's request as expected. The ADOC and the RPN indicated that there had been no collaboration in the development and implementation of resident #03's plan of care to support collaborative care among the staff. The identified PSW was disciplined for not carrying out the instructions of the RPN and providing care to resident #03. [s. 6. (4) (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 the plan of care is based on an assessment of the resident and the resident's needs and preferences and that staff and others involved in the different aspects of care collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: 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 has failed to ensure that the home’s Abuse and Neglect of a Resident-

Actual or Suspected, VII-G-10.00, dated November 2013, contains an explanation of the duty under section 24 to make mandatory reports.

A review of the home's Abuse and Neglect of a Resident-Actual or Suspected, VII-G-10.00, dated November 2013, within the resident care manual, states, "all complaints (verbal or written) from residents, families, visitors and staff that concern a reportable matter as set out in Section 24 of the Long Term Care Act, 2007, shall be immediately reported and investigated". The abuse checklist attachment (b) to this policy will be used to ensure all parties are contacted immediately. A review of the checklist attachment (b) indicated that it is the responsibility of the DOC/Administrator to update the Ministry of Health and Long Term Care Director.
An interview with the ADOC and confirmed that the above mentioned policy does not contain a full explanation of the duty under section 24 to make mandatory reports as required by the legislation.

The ADOC indicated in an interview that the home's policy titled, MOHLTC-Duty to Report, I-F-44.00, dated November 2013, located in the Administration binder, is available to staff and contains an explanation of the duty to report under section 24 of the Long Term Care Act 2007. A review of the policy, contained an explanation of the duty to report under section 24 of the Long Term Care Act 2007, however, the direction is to the Administrator and provides no direction to staff. The policy directs the Administrator as follows:
"The Administrator will:
1. Ensure that all staff members are advised during orientation and annually thereafter, of their duty to report incidents immediately to their supervisor or the Administrator;
2. Ensure that a process for verbally reporting reportable matters within the MOHLTC guidelines is maintained with the management team;
5.Ensure that the incident is investigated and a report is submitted to the MOHLTC Director within 10 days of becoming aware of the incident".

Staff interviews indicated that any alleged suspected or witnessed abuse is to be immediately reported to their supervisor. The ADOC indicated in an interview that staff are educated yearly on mandatory reporting under section 24 of the Long Term Care Act 2007, however, they are directed to report any alleged, suspected or witnessed abuse immediately to their supervisor. The ADOC confirmed that staff have not been directed to inform the MOHLTC Director, and are to inform the Administrator, DOC or the ADOC of any such report and then administration would decide to report based on the allegation. [s. 20. (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 home's Abuse and Neglect of a Resident-Actual or Suspected, VII-G-10.00, dated November 2013, contains an explanation of the duty under section 24 to make mandatory reports, 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. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone 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.

An interview with an identified RN indicated that on an identified date, resident #01 reported that he/she had been physically abused by an identified PSW. The RN indicated

that he/she attempted to call the ADOC after receiving the report from the resident, however, was only able to contact the ADOC by phone on the next day. An interview with the ADOC indicated that she had not been contacted by the identified RN with the above allegations. An interview with the DOC indicated that three days later on an identified date, an email had been received from the RN requesting to speak with the DOC. The DOC and the ADOC indicated in an interview that upon speaking to the RN the same day, initiated a CIS report and subsequently submitted the report to the Director 20 days later. The DOC and the ADOC confirmed that the Director had not been notified immediately of the alleged physical abuse. [s. 24. (1)]

2. On an identified date, the home initiated an investigation where by resident #01 alleged that an identified PSW had physically abused him/her. A review of the home's internal investigation revealed a written statement, wrote by PSW #02 alleging care concerns associated with the identified PSW and that resident #02 had been found with an identified skin integrity concern.

Interviews with the ADOC and the DOC indicated that the care concerns mentioned in the statement provided by PSW #02 had been reviewed. The ADOC indicated that on the day of receiving the statement, interviewed resident #02 and staff working on the resident's home area. The ADOC indicated that the resident had no concerns and that staff indicated that the identified skin integrity issue was of no concern.

During the course of the inspection staff were interviewed as a result of the care concerns with the statement provided by PSW #02. Interview with PSW #02 indicated that while providing care to resident #02, with another identified PSW, noted that the resident had an area of altered skin integrity. PSW #02 indicated that the observation had been reported immediately to an identified RPN and further revealed that the observed altered skin integrity had been documented seven days earlier. An interview with the RPN indicated that he/she was aware of the resident's altered skin integrity, and described it as concerning. The RPN indicated that he/she did not report the resident's altered skin integrity to anyone and was unsure of the cause of the skin concern. An interview with an identified nursing student indicated that he/she observed resident #02's altered skin integrity, and indicated that it may have been physical abuse, but was not sure. The student indicated that the RPN preceptor was made aware, documented the appearance of the altered skin integrity in the progress notes and had not been reported further. The progress notes reviewed on confirmed that an alteration in the resident's skin had been identified.
Interviews with both the ADOC and the DOC confirmed that the above allegations of

abuse and care concerns received from PSW #02, on an identified date, had not been reported to the Director. [s. 24. (1)]

Issued on this 20th day of July, 2015

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

Original report signed by the inspector.