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

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 5, 2015	2015_343585_0004	H-001218-14	Critical Incident System

Licensee/Titulaire de permis

REGENCY LTC OPERATING LP ON BEHALF OF REGENCY
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

THE WILLOWGROVE
1217 Old Mohawk Road ANCASTER ON L9K 1P6

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

LEAH CURLE (585)

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): January 29 and 30, 2015

During the course of the inspection, the inspector(s) spoke with residents, regulated and unregulated nursing staff, dietary staff, scheduling staff, the Assistant Director of Care (ADOC), Directors of Care (DOC's), and the Administrator.

The following Inspection Protocols were used during this inspection:
Dining Observation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **2 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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. The licensee failed to ensure that the written policy to promote zero tolerance of abuse

and neglect of residents was complied with.

A) The home's policy, "Resident Abuse – Abuse Prevention Program – Whistle-Blowing Protection LTC-CA-ALL-100-05-2", revised November 10, 2014, stated "abuse reporting is mandatory, and all staff members are required to report any allegation of abuse immediately to their respective supervisor".

Resident #001's clinical progress notes indicated that on an unidentified date in August 2014, the resident informed a Registered Practical Nurse (RPN) of their concern regarding the care provided to resident #002. The RPN's note stated resident #001 "reported being upset with one of the staff", as the staff was improperly feeding resident #002, and "such action is considered an abuse". The progress note also stated the resident requested for writer to document. The note ended that the writer would report/inform to oncoming registered staff.

Interview with the Registered Nurse (RN) who worked the oncoming shift on the unidentified date in August 2014 reported they recalled the RPN stated they were concerned with the feeding practice provided to resident #002. The RN was unable to confirm if the RPN observed the care provided to resident #002. The RN stated they did not take any actions after they received the information from the RPN, and that the expectation would be to investigate, document, and communicate the concern with the supervisor on call immediately.

The Director of Care (DOC) confirmed they were not made aware of the allegation until the morning of September 2, 2014.

B) The home's resident abuse policy also stated that when a staff member that receives a report of another staff member abusing a resident in any manner, the staff will: ensure the resident is safe, assess the resident immediately, and events will be documented in the resident's health chart.

Documentation completed in resident #001's clinical records indicated that resident #002 was allegedly abused by staff. The home's investigative notes and resident #002's clinical records were reviewed and did not include documentation that they were assessed for safety. The Administrator confirmed the home did not follow their abuse policy, which would include documenting that resident #002 was assessed for safety. [s. 20. (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 and ensuring that without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there their written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that an investigation commenced immediately following a complaint made to the licensee or a staff member concerning the care of a resident or operation of the home where the complaint alleges harm or risk of harm to one or more residents.

Clinical documentation identified that a verbal complaint was made by resident #001 on an unidentified date in August 2014, where they reported to a RPN they observed a staff feeding resident #002 improperly. The documentation stated the "resident said such action is considered an abuse".

A) The night RN who was on duty for the oncoming shift on the unidentified date in August 2014 was interviewed and confirmed they became aware of the alleged improper feeding practice when speaking with the RPN who received the information. The RN confirmed they did not take any action to initiate an investigation.

B) A Critical Incident System (CIS) was submitted by one of the home's DOC's to the Ministry of Health and Long-Term Care on September 2, 2014 when they became aware of the allegation. Following the CIS submission, the home's investigation notes did not state what was done immediately, including any dates or times when actions took place. The DOC confirmed they did not document when investigative actions occurred. The DOC was first unable to verify when they spoke with the alleged staff and others working that shift. The DOC later stated they waited to conduct interviews when they came in for their next shift. After reviewing the home's scheduling files these dates were September 3 and September 5, 2014. The home did not commence actions to conduct their investigation immediately. [s. 101. (1) 1.]

2. The licensee failed to ensure that a documented record was kept in the home that included the actions taken to resolve the complaint, including (c) the date of action, time frames for actions to be taken, and (e) every date on which any response was provided to the complainant.

Documentation for the complaint put forth by resident #001 on an unidentified date in August 2014 did not include dates of action, including but not limited to relevant observations and interviews with staff, or corrective actions, as necessary. Further, the documented record did not include dates to which any response was provided to the complainant beyond the initial date of the investigation. This was confirmed by the DOC. [s. 101. (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 and ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately, and, that a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant, to be implemented voluntarily.

Issued on this 6th day of March, 2015

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

Original report signed by the inspector.