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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 30, 2014	2014_247508_0019	H-000435-14/H-000897-13	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

ROSEANNE WESTERN (508)

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 17, 18, 19, 20, 23, 2014

This inspection was conducted simultaneously with inspections #H-000807-13, H-000815-13, H-000003-14

During the course of the inspection, the inspector(s) spoke with the Administrator, Directors of Care (DOC), Assistant Director of Care (ADOC), Registered staff, Personal Support Workers (PSW), residents and family members.

During the course of the inspection, the inspector(s) toured the facility, interviewed residents and staff, reviewed clinical records, relevant policies and procedures, complaint log, missing laundry forms, and observed care and meal service

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the residents rights were fully respected and promoted when residents, including resident #100, #101, #103, and #104 were not protected from abuse.

a) In July, 2013, resident #100 reported that a staff member had been verbally abusive and mistreated both resident #100 and resident #101. The home initiated an investigation into the complaint and interviewed residents, staff, and family. During the investigation, other concerns were identified regarding this staff member and the allegations of abuse were founded which resulted in the staff member's termination.

b) On three occasions in April, 2014, resident #102 was found by staff lying on top of resident #103 kissing the resident which according to the clinical records was non-consensual.

In June, 2014, resident #102 was discovered by staff in resident #104's room, lying on top of the resident who was described by staff as being in distress and tearful, saying "no, no." The home's staff intervened and re-directed resident #102 back to their room.

It was confirmed by the Director of Care that resident's #103 and resident #104 were touched and kissed by resident #102 and that all incidents were non con-sensual. [s. 3. (1) 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 residents rights are fully respected and promoted by protecting residents from abuse, including residents #100,#101, #103, and #104, to be implemented voluntarily.

WN #2: 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 did not ensure that residents were protected from abuse including resident #103 by anyone and free from neglect by the licensee or staff in the home.

Resident #102 was found by staff on two occasions in April, 2014, lying on top of resident #103 kissing the resident which according to the clinical records was non-consensual The home instituted one to one staff to resident monitoring after the second incident. On an unidentified date in April, 2014, while resident #102 was being monitored, the staff responsible for monitoring the resident left resident #102 alone to interact with another resident. During this time alone, resident #102 left their room and was then discovered by staff kissing resident #103 in a lounge area.

It was confirmed by the Director of Care that the staff left the resident alone, although one to one monitoring had been implemented. [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 to ensure that residents, including resident #103 is protected from abuse, to be implemented voluntarily.

Issued on this 24th day of July, 2014

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