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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Feb 10, 2017	2017_397607_0002	031576-16, 032677-16, 001904-17	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

WINBOURNE PARK
1020 Westney Road North AJAX ON L1T 4K6

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

JULIET MANDERSON-GRAY (607)

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, 24, 25, and 26, 31 and February 2, 2017.

During this Critical incident inspection, the following intakes were inspected: Log's # 032677-16 and 031576-16.

Summary of the intakes:

1) # 032677-16: Regarding an alleged staff to resident physical abuse.
2) # 031576-16: Regarding an alleged staff to resident neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Resident Service Coordinator, a Registered Nurse (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs) and Residents.

During the course of the inspection, the inspector reviewed clinical health records, observed staff to resident interactions, reviewed home specific policies related to Abuse, Reporting of Complaints and Responsive Behaviours.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure the care set out in the plan of care was provided to resident #002 and #003 as specified in the plan, related to transferring and continence care.

A Critical Incident Report (CIR) was submitted to the Director on an identified date for an incident related to an alleged staff to resident physical abuse that occurred at a specified time and date. The CIR indicated resident #002 reported to a staff member that during a specified time, he/she had called to be assisted to the bathroom, and the staff member was rough with the resident during continence care. There were no injuries noted to the resident upon assessment.

Record review and interview with a staff member on an identified date, indicated resident #002 reported that an identified staff member was rough with him/her at a specified time and on an identified date.

Review of the current care plan for resident #002 indicated the resident required two staff assist with transfers.

Further record review and interview with a staff member on an identified date, indicated the staff member did not follow the plan of care, as he/she transferred the resident by him/herself when the incident occurred.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan, as the staff transferred the resident by him/herself when the care plan indicated the resident required two person assist for transfers. [s. 6. (7)]

2. A Critical Incident Report (CIR) was submitted to the Director on an identified date, for an alleged staff to resident neglect and emotional abuse at a specified time and date. The CIR indicated resident #003 expressed that a staff member refused to provide care and was angry with the resident.

Record review of the plan of care for resident #003 indicated the resident requires extensive assistance with personal care needs, and was at high risk for falls.

Record review and interview with a staff member on an identified date, indicated that on a specified time when the incident occurred, resident #003 asked for assistance with continence care multiple times, and assistance was not provided. The resident was told by the identified staff member that he/she would have to wait, as the other staff member he/she was working with was on break. The resident did not receive continence care until approximately half an hour, later.

Interview with the identified Registered staff member who was in charge of the unit, on an identified date and time of the incident, indicated she was aware resident #003 was calling for assistance. The Registered staff member also observed the identified staff member sitting in the dining area, doing some documentation. The Registered staff member further indicated the identified staff member was asked if he/she needed assistance with resident #003's care, and the staff member indicated that he/she did not.

The licensee has failed to ensure that care set out in the plan of care was provided to the resident as specified for resident #003, specifically related to continence care. [s. 6. (7)]

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 care set out in the plan of care was provided to resident as specified in the plan, specifically related to resident #002 and #003, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the home's Complaints procedures is complied with.

Under O. Reg. 79/10 s. 21. Every licensee of a long-term care home shall ensure that

there are written procedures that comply with the regulations for initiating complaints to the licensee, and for how the licensee deals with complaints. 2007, c. 8, s. 21.

During an interview with resident #002 on an identified date, the resident indicated that he/she does not sleep at night, as the roommate is disruptive. The resident further indicated these concerns were brought forward to several staff member's attention, and indicated "nothing is being done about it."

Review of the progress notes of resident #002 during the inspection indicated there were six documented incidents of complaints made by the resident to staff regarding the roommate being disruptive at night, and the resident not being able to sleep. Further review of the progress notes for an identified date and time, indicated that resident #002's Substitute Decision Maker (SDM) had contacted the home, and expressed concerns about the residents' well-being and the resident's roommate.

Interview with a staff member on an identified date, indicated that resident #002 did bring forward the above identified concerns to his/her attention, and that these were reported to another Registered staff member.

Interview with the Registered staff member on an identified date, indicated the concerns were brought forward to his/her attention and this was reported to the Resident Care Coordinator.

Further interview with another Registered staff member on an identified date, indicated that he/she had spoken to resident #002's SDM on an identified date, when he/she expressed concerns about the resident's safety, and this was reported to another Registered staff member.

A review of the Licensee's Management of Concerns, Complaints and Compliments, policy # ADMIN3-010.01, directs:

Education:

The Executive Director will ensure that all staff is educated on how to respond to and manage resident/family/visitor complaints using the H.E.A.R.T Approach. All employees will be instructed to report concerns or complaints to their immediate supervisor.

The H.E.A.R.T. Approach

Hear what they saying
Empathize how they feel
Acknowledge concerns and apologize
Respond and help them
Thank them for telling you their concerns

Verbal concerns, complaints:

1) Upon communication of a complaint or concern, staff will immediately respond using the H.E.A.R.T. approach, and be responsive to resolve the issue. The complaint will be acknowledged immediately if in person or by telephone.
2) If a complaint can be resolved immediately, at the point of service, no further steps are required, other than follow-up as appropriate, as an opportunity for improvement identified through the complaint.
Note: Whenever possible, the complaint is to be resolved as close to the point of service as possible
3) If a concern cannot be resolved immediately at point of service, the individual who is first aware of a concern will initiate the Client Service Response Form (CSR). A copy of the initial form will be forwarded to the member of the team who will be responsible for the resolution of the concern.
4) Where the complaint alleges harm or risk of harm to one or more residents, an investigation shall commence immediately.
5) The concern will be responded to within 24-48 hours (2 business days). The person who raised the concerns will be informed of the actions being taken to resolve the concern. If necessary, the Executive Director may approve additional resources to address the issue. The investigation should be concluded, and the issues resolved within ten days, whenever possible. If the complaint cannot be resolved within ten business days, the complainant shall be notified of the actions taken to date, and provided with a date upon which he/she may expect a resolution.
6) The CSR form will be completed in full, and all actions taken during the investigation will be documented. The CSR is then filed in the complaints management binder.
7) Upon completion of an investigation of the concerns, a response will be provided to indicate what has been done to resolve the complaint, or, if the complaint is found to be unfounded, an explanation will be provided regarding this finding.

Interview with another Registered staff member on an identified date, indicated that he/she was not educated on the CSR form, and has never seen the form before.
Interview with another Registered staff member, indicated he/she has seen the CSR

form, but has never completed one.

Interview with the Resident Care Coordinator on an identified date, acknowledged that a Registered staff member brought the concern to his/her attention and he/she had brought this up in his/her morning management meeting, but did not initiate a CSR form.

Interview with a Registered staff member on an identified date, indicated the first time he/she became aware of resident #002's concern was when the Inspector brought it to his/her attention on an identified date.

Interview with the Administrator, indicated that all staff have been trained on the CSR form, and the expectation is that the form is to be initiated by the person who receives the complaint. The Administrator further indicated that this is an area for improvement.

The licensee has failed to comply with its Management of Concerns, Complaints and Compliments written policy and procedures, specifically related to:
If a concern cannot be resolved immediately at point of service, the individual who is first aware of a concern will initiate the Client Service Response Form and a copy of the initial form will be forwarded to the member of the team who will be responsible for the resolution of the concern. [s. 8. (1) (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 Licensee's Complaints procedures is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident:
(ii) names of any staff members or other persons who were present at, or discovered the incident, and
(iii) names of staff members who responded or are responding to the incident.

A Critical Incident Report (CIR) was submitted to the Director on an identified date, for an incident related to an alleged staff to resident physical abuse, that occurred at a specified time and on an identified date. The CIR indicated resident #002 reported to a staff member that during a specified time, he/she had called to be assisted to the bathroom, and the staff member was rough during continence care. There were no injuries noted to the resident upon assessment.

A review of the home's investigation notes indicated that a second identified staff member was also present, or discovered the incident, but was not identified in the CIR.

The licensee has failed to ensure that the report to the Director included the names of all staff who were present, or either discovered the incident, specifically related to resident #002. [s. 104. (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 ensuring that the report to the Director included the following description of the individuals involved in the incident, including names of any staff members or other persons who were present at or discovered the incident, and names of staff members who responded or are responding to the incident, to be implemented voluntarily.

Issued on this 21st day of February, 2017

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

Original report signed by the inspector.