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
Sep 10, 2014	2014_283544_0027	S-000209-14	Critical Incident System

Licensee/Titulaire de permis

CORPORATION OF THE TOWN OF KIRKLAND LAKE
3 KIRKLAND STREET WEST, POSTAL BAG 1757, KIRKLAND LAKE, ON, P2N-3P4

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

TECK PIONEER RESIDENCE
145A GOVERNMENT ROAD EAST, POSTAL BAG SERVICE 3800, KIRKLAND LAKE, ON, P2N-3P4

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

FRANCA MCMILLAN (544)

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): September 4, 5, 2014 related to :

Log # S- 000209-14

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Care, Assistant Director of Care, Registered Staff, Personal Support Workers, Residents and Families.

During the course of the inspection, the inspector(s) observed daily the delivery of care and services to the Residents, staff to resident interactions, reviewed Residents' health care records, Prevention of Abuse and Neglect Policy, Staff education/training and attendance records regarding the Prevention of Abuse and Neglect Policy and Residents' Rights.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

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:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. A Critical Incident Report was reported to the Director by the home for an alleged incident of verbal abuse by two staff members towards Resident # 001 that occurred.

Inspector # 544 reviewed the Critical Incident.

Inspector # 544 reviewed Resident # 001's plan of care and identified that Resident # 001 could be transferred with a 2 person assist. The plan of care also identified that their wishes were to be moved slowly due to Resident # 001's pain, decrease in hip flexion and lower leg strength. Resident # 001 was able to weight bear.

Inspector # 544 interviewed Resident # 001 and found Resident # 001 was very articulate during the interview.
Resident # 001 told Inspector that they recalled the incident very well and they felt that their rights were violated and not respected when the staff came in to perform a transfer from their bed to their wheelchair. Resident # 001 further stated that they felt they were not able to exercise their right to make the decision to get out of bed without using the mechanical lift. Resident # 001 told the Inspector that using the mechanical lift, to assist him out of bed, was very painful and uncomfortable.

Resident # 001 stated that Staff # 105 and Staff # 106, who approached him and assisted him to get out of bed, would not allow them to speak and offer alternatives to assist them with the transfer, that would be less painful for them.
Resident # 001 stated Staff # 105 they would have to stay in their bed for the day.
Resident # 001 told Staff # 105 and Staff #106 to leave them alone and leave their room as the staff were not providing individual care based on Resident # 001's choice.
This was a concern to Resident # 001 as they felt the right to refuse the mechanical lift was not respected.

The licensee has failed to ensure that Resident # 001's right to participate in decision-making was respected. [s. 3. (1) 9.]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. Inspector # 544 reviewed the home's policy regarding Prevention of Abuse and Neglect namely: Administration- Zero Tolerance of Abuse and Neglect- Section Risk Management, Reviewed January 2014
It is written that, " the Residents' Bill of Rights and the the Policy on Zero tolerance of Abuse and Neglect will be reviewed with each new employee during orientation and annually thereafter.

Inspector # 544 reviewed the staff education/training attendance records and found that only 55/94 of the direct care staff were trained in the year 2013 regarding the Prevention of Abuse and Neglect Policy. Only 25/86 of the staff were trained annually in Part 1 of the Prevention of Abuse and Neglect policy in 2013.
This was confirmed by Staff # 100 and Staff #101.

The licensee has failed to ensure that training had been provided annually to all staff regarding the home's Zero Tolerance of Abuse and Neglect policy. [s. 76. (4)]

Issued on this 10th day of September, 2014

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