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
Aug 5, 2015	2015_380593_0014	S-000560-14, 650-14	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

GILLIAN CHAMBERLIN (593)

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): May 19 - 22, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Director of Care (ADOC), Registered Nursing Staff, Dietary Staff, Activation Staff, Maintenance Staff, Personal Support Workers (PSW) and residents.

The inspector also observed the provision of care and services to residents, observed staff to resident interactions, observed resident to resident interactions, observed residents environment, reviewed resident health care records, reviewed staff training records and reviewed home policies.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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 has failed to ensure that the written policy to promote zero tolerance of

abuse and neglect of residents is complied with.

A Critical Incident (CI) was submitted to the Director of the Ministry of Health and Long-Term Care (MOHLTC) in relation to reported verbal abuse by #S-100 toward resident #002. It was reported that #S-101 heard #S-100 speak in a threatening way toward resident #002. It was observed by #S-101 that resident #002 was becoming upset with the interaction with #S-100.

During an interview with Inspector #593 May 19, 2015, #S-103 said that the abuse allegations were reported to them by #S-102 via a voice message left on their phone Thursday evening. #S-103 said that they were not back in the home until the following Monday and therefore did not receive the message until four days after the incident occurred. #S-103 advised that #S-102 should have reported the abuse allegations directly to the Administrator.

During an interview with Inspector #593 May 19, 2015, #S-102 said that they did not witness the incident however it was reported to them by one of the PSWs. #S-102 said that they reported the allegations to #S-103 who is #S-100's immediate supervisor via a voice message. #S-102 added that as per the home's policy, they should have reported the incident to the charge nurse and then one of them would have reported it further to the Administrator.

During an interview with Inspector #593 May 20, 2015, the Administrator advised that #S-102 reported the allegations to #S-103 via voice message on a Thursday evening, however #S-103 was not in the home on the Friday and therefore did not receive the message until the following Monday. The Administrator added that they told #S-102 that they should have reported this to the charge nurse who is to report directly to the Administrator.

A review of the home's Zero Tolerance of Abuse and Neglect Policy dated January 2014, found that any persons who are reporting any witnessed or suspected resident abuse or neglect are to report to the Team Leader who notifies the charge nurse immediately. The charge nurse receiving the report is to notify the Administrator/DOC or ADOC, including after-hours, immediately upon receipt of the alleged, witnessed or unwitnessed abuse or neglect, and initiate the investigation.

#S-102 failed to report the abuse allegations to the charge RN immediately and therefore the Administrator was not notified immediately by the charge RN as per the home's

policy. [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 ensuring that the written policy to promote zero tolerance of abuse and neglect of residents is complied with, specifically but not limited to the home's internal reporting procedures, to be implemented voluntarily.

WN #2: 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 suspicions of abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident is immediately reported to the Director.

A Critical Incident (CI) was submitted to the Director of the Ministry of Health and Long-Term Care (MOHLTC) in relation to reported verbal abuse by #S-100 toward resident #002. It was reported that #S-101 heard #S-100 speak in a threatening way toward

resident #002. It was observed by #S-101 that resident #002 was becoming upset with the interaction with #S-100.

The CI was submitted however, the incident actually occurred five days earlier than when the CI was reported to the Director of the MOHLTC.

During an interview with Inspector #593 May 19, 2015, #S-103 said that the abuse allegations were reported to them by #S-102 via a voice message left on their phone Thursday evening. #S-103 said that they were not back in the home until the following Monday and therefore did not receive the message until four days after the incident occurred. #S-103 advised that #S-102 should have reported the abuse allegations directly to the Administrator.

During an interview with Inspector #593 May 19, 2015, #S-102 said that they did not witness the incident however it was reported to them by one of the PSW's. #S-102 advised that they reported the allegations to #S-103 who is #S-100's immediate supervisor via a voice message. #S-102 added that as per the home's policy, they should have reported the incident to the charge nurse and then one of them would have reported it further to the Administrator. #S-102 added that they did not realize that #S-103 was not in the following day.

During an interview with Inspector #593 May 20, 2015, the Administrator advised that #S-102 reported the allegations to #S-103 via voice message on a Thursday evening, however #S-103 was not in the home on the Friday and therefore did not receive the message until the following Monday. The Administrator added that they told #S-102 that they should have reported this to the charge nurse who is to report directly to the Administrator.

A review of the home's Zero Tolerance of Abuse and Neglect Policy dated January 2014, found that all persons, including the home and all staff members are to make immediate reports to the Director when there is reasonable suspicion that certain incidents occurred or may occur.

Non-compliance was previously identified under inspection 2014_332575_0021, pursuant to LTCHA, 2007 S.O. 2007, c.8, s. 24 (1) in relation to failing to immediately report the alleged abuse of a staff member towards a resident in the home. [s. 24. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is immediately informed of an outbreak of a reportable disease or communicable disease.

A Critical Incident (CI) was submitted to the Director of the Ministry of Health and Long-Term Care (MOHLTC) in relation to an outbreak of Influenza A affecting five residents and one staff member. The outbreak was declared by Public Health however the CI was not submitted to the Director until six days later.

During an interview with Inspector #593 May 21, 2015, the ADOC advised that to declare an outbreak, two residents must be exhibiting the same symptoms. The second resident with symptoms was identified on the same day that the home declared the outbreak. This was the same day that they contacted Public Health to advise them of the outbreak. The ADOC reported that the Director of the MOHLTC was not notified until six days later, due to the holidays, as there were no management back in the home to complete the CI until this time.[s. 107. (1) 5.]

Issued on this 27th day of August, 2015

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

Original report signed by the inspector.