Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 26, Jul 16, 17, 18, 19, 20, 2012	2012_054133_0027	Critical Incident

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, Registered and Non Registered Nursing Staff.

During the course of the inspection, the inspector(s) reviewed a Critical Incident report, reviewed documentation related to the Home's investigation into this reported Critical Incident, reviewed the home's policy entitled "Zero Tolerance of Abuse and Neglect" (most recent revision date March 2011), reviewed training records for 3 staff persons.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Training and Orientation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed comply with LTCHA, 2007, c.8, s.3(1)1 in that the licensee failed to ensure that every resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity is fully respected and promoted.

On a day in March 2012, the home's Administrator reported to the MOHLTC via the Critical Incident reporting system that during a meal, in one of the care unit dining rooms, a staff person (#S100) was observed, by colleagues, nursing students and the student's instructor, to have physically restrained two residents (resident #001 and resident #002), attempted to force feed them and forced one of the residents (#002) to swallow a drink. The Administrator's investigation into this incident brought forward the following details which are within the witnesses' written statements:
- Staff person #S100 was observed by staff person #S101 to restrain resident #001 by placing their (staff person #S100) arm over the resident's arms and then attempted to force feed that resident.
- Staff person #S101 intervened and offered to take over feeding resident #001, then staff person #S100 proceeded to attempt to feed another resident #002.
- Student #S103 observed that resident #002 was agitated and moving their hands around, so staff person #S100 held the resident's hands down and held a glass of juice to the resident's mouth.
- Student #S103 offered to take over feeding resident #002 but staff person #S100 declined.
- Student #S103 observed that staff person #S100 held one of resident #002's hands down and attempted to feed them a food item but the resident would not eat it.
- Student #S103 observed that staff person #S100 then put one of the resident's hands between their (staff person #S100) legs to hold it in place and attempted to feed resident #002 another food item but the resident would not eat it.
- At this point, staff person #S100 decided to remove resident #002 from the dining room and attempted to remove the resident's apron.
- Student #S103 observed that resident #002 was hitting at staff person #S100 as they attempted to remove the resident's apron so they asked student #S103 for help. Student #S103 reports that they rubbed the resident's hands and arms telling them everything was okay.
- Staff person #S102 reports that as this was occurring, staff person #S100 poured a drink into the resident's mouth.
- Resident #002 was then removed from the dining room by staff person #S100.
- Student #S103 reports that the resident didn't get anything to eat for that meal.

Following the Administrator's investigation into this incident, staff person #S100's employment at the home was terminated.

The right of both resident #001 and resident #002 to be treated with courtesy and respect and in a way that fully recognizes the residents' individuality and respects the residents' dignity, was not fully respected.

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 with the requirement that the licensee shall ensure that the right of every resident to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity is fully respected and promoted, to be implemented voluntarily.

WN #2: 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 subsections:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The inspector reviewed the home's policy titled "Zero Tolerance of Abuse and Neglect" (with most current review date March 2011). The inspector noted that the policy refers to some consequences for staff who abuse or neglect residents. On page 9 of 13 the policy contains direction to Administrator/Director of Care or Assistant Director of Care to do the following: "determine the appropriate management actions to be taken as a result of the findings of investigation (e.g. education, discipline, policy revision, mandatory reporting to relevant professional college)". The inspector noted that the policy fails to set out the consequences for any other persons who abuse or neglect residents (i.e. volunteers, visitors, family members, etc). The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents sets out consequences for those who abuse or neglect residents. [LTCHA, 2007, c.8, s.20(2)f]
2. The inspector reviewed the home's policy titled "Zero Tolerance of Abuse and Neglect" (with most recent review date March 2011). The inspector noted that on page 4 of the policy there is a paragraph that speaks to the duty under section 24 of the Act to make mandatory reports. It is written that "certain persons, including the Home and certain staff members" are required to make mandatory reports. There are no staff members who are exempt from the duty under section 24 of the Act. The duty under section 24 of the Act to make mandatory reports lies with any person (except for a resident) who has reasonable grounds to suspect that any of the areas described under section 24 of the Act have occurred or may occur. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents contains an explanation of the duty under section 24 of the Act to make mandatory reports. [LTCHA, s. 20(2)(d)]

WN #3: 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 subsections:

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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. As is required by LTCHA, 2007, c.8, s.24(1)1, Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident was not reported to the Director of the Ministry of Health and Long Term Care (MOHLTC).

On a day in March 2012, the home's Administrator reported to the MOHLTC via the Critical Incident reporting system that during a meal, in one of the care unit dining rooms, a staff person (#S100) was observed, by colleagues, nursing students and the student's instructor, to have physically restrained two residents (resident #001 and resident #002), attempted to force feed them and forced one of the residents (#002) to swallow a drink.

On April 3rd, 2012, Inspector #151 contacted the Administrator in order to obtain further information. The Administrator informed inspector #151 that staff person #S100 had similar performance issues, approximately 6 months prior to this incident. The Administrator was asked to provide further information about this past incident on June 26th 2012 when inspector #131 was at the home to conduct a Critical Incident inspection, related to the reported Critical Incident that occurred in March 2012. The Administrator informed the inspector that staff person #S100 had been observed attempting to force feed resident #001 in the past (approximately 6 months prior to the incident that occurred in March 2012). The Administrator explained that she was the Assistant Director of Care (ADOC) at the time, that the incident was reported to her by a now retired Activity Aid (AA), and that there was no documentation maintained of this occurrence and therefore she was unable to provide specific dates for the occurrence. The Administrator described the incident, as reported to her, as follows: the AA was in one of the care unit dining rooms cooking a food item and had their back to the staff and residents, they heard the sound of a resident in distress and turned around to see staff person #S100 attempting to force feed resident #001, and resident #001 was waving their arms around and "having none of it". The current Administrator indicated to the inspector that after she received report of this from the AA she followed up with staff person #S100 and advised that force feeding the residents was not acceptable. The current Administrator (who was ADOC at the time), stated that she reported the incident to the Administrator in place at the time, that there was no further follow up action that she is aware of and that she does not believe the Administrator in place at the time reported the incident to the Director of the MOHLTC. The inspector has since confirmed that this incident involving staff person #S100 and resident #001 was not reported to the Director of the MOHLTC.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance
Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,
(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;
(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
(c) identifies measures and strategies to prevent abuse and neglect;
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and
(e) identifies the training and retraining requirements for all staff, including,
(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and
(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. The inspector reviewed the home's policy titled "Zero Tolerance of Abuse and Neglect" (most current revision date March 2011). The inspector noted that the policy does not contain procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected. The inspector noted that on page 8 of 13 the policy contains direction to the clinical staff responsible for care of the resident(s) harmed by the abuse or neglect to do the following: ensure the safety of the resident(s) involved, conduct a physical assessment of the resident and, if injury, pain or suspected injury are found, to follow up with the physician or other health practitioner. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected. [O. Reg. 79/10, s.96(a)]
2. The inspector reviewed the home's policy titled "Zero Tolerance of Abuse and Neglect " (with most current review date March 2011). The inspector noted that the policy does not contain procedures and interventions to deal with persons (including staff, volunteers, visitors...etc) who have abused or neglected or allegedly abused or neglected residents, as appropriate. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate. [O. Reg. 79/10, s. 96.(b)]
3. The inspector reviewed the home's policy titled "Zero Tolerance of Abuse and Neglect" (with most recent review date March 2011). The inspector noted that the policy does not identify the training and retraining requirements for all staff including: training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations. The licensee has failed to ensure the home's written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff. [O. Reg. 79/10. s.96(e)(i)(ii)]

Issued on this 20th day of July, 2012

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

Jessica Lapensée