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 3, 2014	2014_306510_0012	H-000901-13/H-000251-14	Critical Incident System

Licensee/Titulaire de permis

SPECIALTY CARE MISSISSAUGA INC.
400 Applewood Crescent, Suite 110, VAUGHAN, ON, L4K-0C3

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

SPECIALTY CARE MISSISSAUGA ROAD
4350 MISSISSAUGA ROAD, MISSISSAUGA, ON, L5M-7C8

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

IRENE PASEL (510)

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 23, 26, 27, 28, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Manager for MDS, Registered Staff, and Personal Support Workers.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services provided on resident home areas and reviewed relevant documents including but not limited to: policies and procedures, meeting notes, and clinical records

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:
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. 2007, c. 8, s. 3 (1).

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 of the long-term care home did not ensure that the following rights of residents were 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. 2007, c. 8, s. 3 (1).

Resident #1 had an Infection and required frequent toileting with the assistance of two staff. Resident #1 was continent and competent.
The Plan of Care for Resident #1 noted the resident refused to wear a brief even though their family encouraged use of a brief.
Progress notes the day prior to the incident stated resident refused to wear brief.
Internal investigation notes stated that the staff member acknowledged that after toileting Resident #1 at 0001 hours on an identified date in 2013, they put a brief on Resident #1 even though the resident did not have a brief on prior to toileting. Staff further reported that after putting the brief on the resident, the resident stated "it was no good".
The staff was disciplined for having violated resident's rights.
DOC confirmed that discipline had been issued to the staff member. [s. 3. (1) 1.]

2. The licensee of a long-term care home did not 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).

Progress notes on an identified date reported that Resident #2 was verbally abused by the family member of Resident #1.
Staff reported that on an identified date in 2014, they witnessed the family member verbally threaten Resident #2 with injury. It was reported the resident stated "what" when spoken to.
Staff reported they removed the resident from the situation.
Administrator confirmed that this incident occurred and she met with the identified family member to confirm expected behaviors.
Documentation of the meeting confirmed the family member was advised of the Home's Code of Conduct, directed to speak with staff about concerns and never speak to residents.
The Administrator reported that the family member apologized to the staff involved. [s. 19. (1)] [s. 3. (1) 2.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee did not ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented. O. Reg. 79/10, s. 30 (2).

A Critical Incident Report submitted to the Director described an altercation involving Resident #1, Resident #2 and Resident #4 that occurred on an identified date in 2014.

As staff distracted Resident #4, Resident #1 fell to the floor. The fall was unwitnessed.
Review of progress notes for Resident #4 for the identified date do not reflect the incident, the resident's behavior associated with the incident or actions taken by staff.
The Manager of Minimum Data Set (MDS) reviewed the progress notes and confirmed the absence of relevant documentation regarding the behavior of resident #4.
The DOC confirmed that documentation in the progress notes regarding this incident was missing. [s. 30. (2)]

Issued on this 4th day of June, 2014

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