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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 14, 2019	2018_560632_0021	025726-18, 026723-18	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of Halton
1151 Bronte Road OAKVILLE ON L6M 3L1

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

Creek Way Village
5200 Corporate Drive BURLINGTON ON L7L 7G7

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

YULIYA FEDOTOVA (632)

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): November 22, 23, 26, 27, 28, 2018.

The following intakes were completed in this Critical Incident System (CIS) inspection:

Log # 025726-18 was related to prevention of abuse and neglect.
Log #026723-18 was related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Senior Nursing Manager (SNM), the Manager of Resident Care (MRC), the Administrative Clerk, the Resident Care Clerk, Employee Relations Specialist Halton Regional Center – Human Resources, the Resident Assessment Instrument (RAI) - Minimum Data Set (MDS) Co-ordinator, Personal Support Workers (PSWs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), residents and their families.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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	Légende 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 that the care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident System (CIS) report M623-000015-18 was submitted to the Director on an identified date in September, 2018, related to a fall resulting in injury for resident #002. Review of resident #002's plan of care indicated that the resident required an identified intervention. Review of the specified assessment indicated that the resident would benefit from a specified intervention. Interview with PSW #115, who provided care to the resident prior to the fall, confirmed that resident #002 was not transferred according to the residents assessed needs. On an identified date in November, 2018, the MRC #114, who conducted the investigation of the incident, acknowledged that transfer performed by PSW #115 was not according to the resident's plan of care.

The home failed to ensure that the care set out in the plan of care for resident #002 was provided to the resident as specified in the plan.

Please note: this non-compliance was issued as a result of CI log #026723-18. [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 and ensuring that the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

The Long Term Care (LTC) Homes Act, 2007, defined physical abuse as the use of physical force by anyone other than a resident that caused physical injury or pain.

A CIS report M623-000014-18 was submitted to the Director on an identified date in September, 2018, alleging abuse by PSW #106 towards resident #001, which occurred on an identified date in September, 2018.

Interview with resident #001 on an identified date in November, 2018, indicated that PSW #106 performed identified activity towards resident #001 and the resident was injured.

Progress note review indicated that the resident complained to RN #120 about PSW #106, and alleged that they had caused an injury, while providing care.

According to the records, an assessment on the day of the incident confirmed an injury to resident #001.

Review of the specified assessment conducted for resident #001 indicated that the resident had altered skin integrity prior to the incident on an identified date in September, 2018.

The inspection and home's investigation were unable to confirm that the altered skin integrity was caused by the action of PSW #106, however review of progress notes indicated that resident #001 had verbalized symptoms of injury. Progress notes indicated that the resident still remembered the incident on an identified date in September, 2018, and the resident was under distress.

The licensee failed to ensure that resident #001 was protected from abuse by anyone.

Please note: this non-compliance was issued as a result of CI log #025726-18. [s. 19. (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 and ensuring that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

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:

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 failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or might occur, immediately reported the suspicion and the information upon which it was based to the Director: 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.

A CIS number M623-000014-18 was submitted to the Director on an identified date in September, 2018, related to an allegation of abuse by PSW #106 towards resident #001. The investigation notes, Critical Incident (CI) Report review and RPN #104 and RN #105 interviews indicated that the incident was not reported to the Director immediately by staff #104 and #105.

As per the home's policy titled "Prevention, Reporting and Elimination of Abuse and Neglect", policy number 01-05-03 (revision date January 2017), staff, who had reasonable grounds to suspect abuse of a resident, were expected to immediately report the suspicion and the information upon which it was based to the Director. The home's expectation on reporting of suspected abuse was confirmed with SNM on an identified date in November, 2018, who indicated that the expectations on immediate reporting were communicated to the staff during annual staff training, which was completed in 2017. The training materials were based on 2017 Education Booklet, where it was indicated that everyone was legally obligated to immediately report any alleged, witnessed or suspected abuse to their manager and to ensure the Ministry was notified by calling the Long-Term Care toll free ACTION Line.

RPN #104 and RN #105 did not immediately notify the Director about the incident, which was acknowledged by SNM.

The licensee failed to ensure that the alleged abuse towards resident #001 by PSW #106 was reported to the Director immediately.

Please note: this non-compliance was issued as a result of CI log #025726-18. [s. 24. (1)]

Issued on this 24th day of January, 2019

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

Original report signed by the inspector.