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

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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
Mar 10, 2014	2014_196157_0002	000228,000845,001347,000973	Critical Incident System

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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

PATRICIA POWERS (157), MARIA FRANCIS-ALLEN (552), MATTHEW STICCA (553)

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): January 21, 22, 23, 2014

The purpose of this inspection was to conduct a critical incident inspection for the following logs:
O-000973-12, O-0001347-12, O-002355-12, O-000228-13, O-000697-13, O-000845-13, O-001152-13, O-001235-13, O-000040-14

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Director of Quality Nursing (DQN), Clinical Nurse Specialist (CNS), RAI Coordinator, Behaviour Support Program Coordinator (BSO), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents.

During the course of the inspection, the inspector(s) reviewed the clinical health records of identified residents, reviewed the home's policies and procedures related to Falls Prevention and Management, Responsive Behaviours and Abuse and Neglect, reviewed records of education programs related to abuse and neglect and education session attendance records, reviewed the home's investigation records related to falls, responsive behaviours and incidents of abuse and neglect, reviewed behaviour monitoring procedures and interventions for identified residents, observed staff to resident interactions, observed the provision of resident care.

The following Inspection Protocols were used during this inspection:
Admission Process
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for resident #03 set out clear direction to staff and others who provide direct care to the resident.

Related to Log #O-000973-12, Critical Incident Report:
The plan of care for resident #03 indicates that the resident was known to demonstrate responsive behaviours which resulted in risk of harm to other residents. The written plan of care provided the following direction:
- "Remove resident from any stressful situation" but failed to provide clear directions related to the situations that would be stressful to this resident. [s. 6. (1) (c)]

2. The licensee failed to ensure that the written plan of care for resident #01 set out clear direction to staff and others who provide direct care to the resident.

Related to log #O-000040 Critical Incident Report:
Critical Incident Report states that on an identified date resident #01 experienced two falls. The resident was assessed and was transferred to hospital for further assessment. The resident was admitted to hospital for treatment the home was subsequently advised that the resident was deceased.
Resident #01's clinical health record indicates the following:
- The initial Physiotherapy assessment of resident #01 identified the resident as being a "high risk" for falls.
- The written plan of care for Resident #01 under the Falls/Balance focus, identified the resident as being a "low risk" for falls.
- The action plan section of the home's Post Fall Investigation Record, identified Resident #01 as being a "medium risk" for falls.
- Four Falls Risk Assessments were completed for resident #01 on identified dates. Each assessment identified the resident as being a "high risk" for falls. The outcomes of these assessments were not included in the development and implementation of the plan of care for Resident #01 and as a result the plan of care failed to provide clear direction related to the resident's risk of falls. [s. 6. (1) (c)]

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 to ensure that the written plans of care for residents:
- identified as demonstrating responsive behaviours and;
- identified as being at risk for falls
provide clear direction to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. Related to Log #O-000228-13, Critical Incident Report:
The licensee failed to ensure that an alleged, suspected or witnessed incident of abuse and neglect of resident #22 was immediately investigated.
The Critical Incident Report identifies the receipt of a report from a family member who witnessed PSW neglect of resident #22 and witnessed the PSW being verbally abusive to the resident and to family members:
- when the resident waited in excess of an hour for assistance to the bathroom; and
- when the PSW responsible for the resident's care complained about already toileting the resident, about the number of residents the employee is required to care for and suggested that the family provide the resident's care.
A further written complaint from the resident's family confirms the information reported in the CI Report.
The Critical Incident Report identified that the alleged incident occurred on the same day the report was submitted.
The home's incident investigation and interview notes indicate that the investigation and interviews were not commenced until five days after the incident.

A meeting held with family members of resident #22 in order to review the incident/investigation and follow up actions. Meeting minutes indicate indicate the following:
- apologies were offered from the Administrator for the delay in resolving the matter
- Administrator stated that the individual involved in the incident was part time which added to the delay in completing the investigation
- Administrator stated "we take ownership in that we should have communicated with you more effectively"
- In response to the family concerns, the Administrator stated, "Yes we dropped the ball" [s. 23. (1) (a)]

2. Related to Log #O-000228-13, Critical Incident Report:
The licensee failed to report to the Director the results of the investigation into the allegations of neglect and verbal abuse of resident #22 and the actions taken as a result of the investigation.
The Critical Incident report identifies a report from a family member about witnessing an identified PSW neglect of resident #22 and the PSW being verbally abusive to the resident and to family members.
There is no evidence that the results of the investigation of the alleged incident or the actions taken were reported to the Director. [s. 23. (2)]

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 to ensure that:
- alleged, suspected or witnessed incidents of abuse and neglect of residents are immediately investigated
- the results of investigations into allegations of neglect and abuse and actions taken are reported to the Director, 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. Related to Log #O-000845-13, Critical Incident Report:
The licensee failed to immediately notify the Director when there were reasonable grounds to suspect that a resident was physically abused by a staff member resulting in harm to the resident.

The Critical Incident report identifies an incident of a staff member physically abusing a resident on an identified date when a PSW was witnessed and admitted to striking resident #23 on the hand in response to the resident punching the staff member. The incident resulted in an injury to the resident. There is no evidence that the Director was immediately notified. [s. 24. (1)]

2. Related to Log # O-002355-12, Critical Incident Report:
The licensee failed to immediately report to the Director, the suspicion of abuse of a resident by anyone that resulted in physical harm to the resident and the information upon which the suspicion is based.

The Critical Incident Report identifies that an incident of resident physical abuse of another resident occurred on an identified date when resident #31 grabbed a co-resident on the lower arms resulting in the co-resident sustaining an injury. There is no evidence that the Director was immediately notified.
The Critical Incident Report incorrectly categorizes this incident as "Other" when the circumstances provided clearly categorize it as "Abuse/Neglect".

Related to Log #O-000697-13, Critical Incident Report:
The Critical Incident Report identifies that an incident of resident physical abuse of another resident occurred on an identified date resulting in the co-resident sustaining an injury. There is no evidence that the Director was immediately notified. [s. 24. (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 to ensure that when there are reasonable grounds to suspect that 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, the suspicion and the information upon which it is based is immediately reported to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. Related to Log#O-002355-12, Critical Incident Report:

The licensee failed to identify the behavioural triggers for resident #31 who demonstrated responsive behaviours.

The Critical Incident reports that on an identified date, resident #31 struck a co-resident resulting in the co-resident sustaining an injury.
A review of the Behavioural Assessment Tool (BAT) for resident #31 indicates that there were no triggers or interventions provided for the following identified behaviours:

- Agitated Behaviour (evaluated as high risk)
- Verbally Aggressive/ Angry Behaviour (evaluated as high risk)

- Physically Aggressive/ Angry Behaviour (evaluated as high risk)
As a result of the failure to identify triggers and appropriate interventions, the plan of care for resident #1 failed to reflect the current needs of the resident.

The Multidisciplinary Progress Notes for resident #31 for an identified period, identifies 6 incidents of physical aggression.

Staff interviews conducted by the inspector identified the following:
- Staff #114 reported that resident #31 was part of the BSO program. Staff member identified known behaviours demonstrated by the resident.
- Staff #102 reported that the home had difficulty identifying triggers for resident #31's behaviours
The plan of care for resident #01 failed to identify a known trigger demonstrated by resident #31.

The plan of care directed staff to remove the resident from the situation causing anger and distress, and to remove the resident from any stressful situation. The direction failed to provide specific information related to what situations would trigger resident #31's anger and distress and what situations the resident could potentially find stressful. [s. 53. (4) (a)]

2. Related to Log#O-002355-12, Critical Incident Report:

The licensee failed to take actions to respond to the needs of resident #31's responsive behaviours including assessments, reassessments and interventions. The Behavioural Assessment Tool (BAT), failed to identify triggers for resident #31's behaviours and failed to identify appropriate interventions to manage the resident's responsive behaviours which were identified as high risk, including agitation, verbal aggression and physical aggression.

The MDS assessment indicates that Resident #31 was assessed as demonstrating responsive behaviours and being an appropriate admission to the BSO program. However, the BAT completed for the resident was the only assessment conducted for the duration of the resident's stay in the home. The home failed to assess and reassess resident #31 who was demonstrating aggressive responsive behaviours.

Resident #31's written plan of care provided the following direction:
Focus: Verbally abusive behaviour - is verbally abusive, monitor for signs of anger or

distress. Remind Resident #31 that inappropriate language is unacceptable.
Focus: Physically abusive behaviour - is physically abusive, monitor for signs of anger or distress and remove Resident #31 from the situation.

Resident #31's progress notes for an identified period, do not provide any documentation related to the resident's response to interventions or the effectiveness of the interventions. Progress notes identify 3 occasions when the resident demonstrated verbally or physically aggressive behaviours directed towards staff or co-residents:

Incident #1 - Resident #31 in nursing station and got a book, staff tried to retrieve book. Resident #31 got upset and grabbed staff's necklace and scratched the staff's hand with nails.
- No indication of the application of interventions or the resident's response to any interventions used.

Incident #2: Verbal argument between Resident #31 and co-resident, argument took place in the front lobby.
- No indication of the application of interventions or the resident's response to any interventions used.

Incident #3: Resident #31 struck a co-resident multiple times. Staff removed Resident #31 from the altercation.
- The plan of care failed to provide staff with interventions to prevent the altercation. Planned interventions directed staff only to remove resident #31 from the situation, which they did but only after the altercation occurred. [s. 53. (4) (c)]

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 to ensure that for each resident demonstrating responsive behaviours, behavioural triggers are identified where possible and actions are taken to respond to the needs of the resident including assessments, reassessments and interventions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Related to Log #O-000040-14, Critical Incident Report:
The licensee failed to ensure, where the Act or Regulation requires the licensee to have, institute or otherwise put in place a plan, protocol, procedure, strategy or system, that such plan, protocol, procedure, strategy or system any plan, policy, procedure, strategy or system was complied with.

Falls Prevention Policy, ID RSL-SAF-055 directs the following:
Procedures and Management of Complications:
- residents identified as medium and high risk must have the problems with interventions documented on the plan of care and those at high risk noted on the daily report. The Care Plan will be reviewed and updated quarterly or as the resident's status changes such as with re-admission from hospital.

The home failed to comply with the established policy as evidenced by the following:
- The Physiotherapy initial assessment for resident #01 indicated that this resident was a "high risk" for falls.
- The written plan of care for resident #01 under the Falls/Balance focus identified the resident as being a "low risk" for falls.
- The CI report indicates that resident #01 experienced a fall on an identified date. The home's post fall investigation report indicated that the resident was now assessed to be at "medium risk" for falls.
The written plan of care was not revised to accurately reflect resident #01's risk for falls and associated interventions. [s. 8. (1)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. Procedures for initiating complaints to the licensee was not posted at the time of review by the inspector. Procedures were subsequently posted by the Administrator. [s. 79. (3) (e)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. Related to Log #O-000228-13, Critical Incident Report:

The licensee failed to ensure that resident #22's SDM was notified of the results of the investigation of an alleged abuse or neglect investigation immediately upon the completion.
The Critical Incident report identifies a report from a family member who witnessed PSW neglect of resident #22 and the PSW being verbally abusive to the resident and to family members.
A further written complaint confirms the information reported.
A meeting held with family members of resident #22 in order to review the incident/investigation and follow up actions. Meeting minutes indicate the following:
- the Administrator expressed apologies for the delay in resolving the matter
- a family requested an explanation of the investigation and expressed that calls were made to the home weekly by a family member with no response from the home
- the Administrator stated that the individual involved in the alleged incident was part time which added to the delay in completing the investigation
- a family member stated that there was no response to her calls over a three week period
- the Administrator responded "we take ownership in that we should have communicated with you more effectively"
- family members expressed surprise that they visited and saw the employee back at work
- Administrator replied, "Yes we dropped the ball"
- Family member stated "So, I still haven't had an outcome of the investigation re: validation of the abuse"
- Administrator responded that the employee's "actions were inappropriate and this was managed." and that the "employee was re educated to the expectations of the home" [s. 97. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. Related to log #O-000845-13, Critical Incident Report:
The licensee failed to ensure that the appropriate police force was immediately notified of the alleged, suspected or witnessed incident of physical abuse of resident #23 by a staff member.
The Critical Incident report identifies an incident of a staff member physically abusing a resident when a PSW was witnessed and admitted, to striking resident #23 on the hand in response to the resident striking the staff member.
The appropriate police force was not immediately notified of the witnessed incident of abuse. The CI report indicates that Durham Regional Police were contacted by the home five days after the incident. Police visited the home and no charges were laid.
[s. 98.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits saillants :

1. Related to Log #O-000228-13, Critical Incident Report:

The licensee failed to submit a copy of a written complaint to the Director along with a written report documenting the response the licensee made to the complainant.

The Critical Incident report submitted on an identified date identifies a report from a family member of resident #22 who witnessed a PSW neglect resident #22 and witnessed the PSW being verbally abusive to the resident and to family members.

The Administrator received two detailed written complaints related to the reported incident.

There is no evidence that the licensee submitted a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant. [s. 103. (1)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. Related to Log #000228-13, Critical Incident Report:
The licensee failed to report to the Director, the names of staff members who were present at or discovered an incident of verbal abuse and neglect of a resident.

The Critical Incident identifies a report from a family member of resident #22 who witnessed a PSW neglecting a resident and being verbally abusive to the resident and to family members.
The name of the PSW alleged to have been involved with the incident was not reported to the Director. [s. 104. (1) 2.]

2. Related to Log #O-000228-13, Critical Incident Report:

The licensee failed to ensure that the report to the Director provided the outcome or current status of the individual involved in the incident.

The Critical Incident identifies a report from a family member of resident #22 who witnessed a PSW neglecting a resident and being verbally abusive to the resident and to family members.
The Critical Incident report provided an inaccurate report of actions taken in response to this incident and the analysis and follow up action taken. [s. 104. (1) 3.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 225. Posting of information

Specifically failed to comply with the following:

s. 225. (1) For the purposes of clause 79 (3) (q) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 79 of the Act includes the following:
1. The fundamental principle set out in section 1 of the Act. O. Reg. 79/10, s. 225 (1).
2. The home's licence or approval, including any conditions or amendments, other than conditions that are imposed under the regulations or the conditions under subsection 101 (3) of the Act. O. Reg. 79/10, s. 225 (1).
3. The most recent audited report provided for in clause 243 (1) (a). O. Reg. 79/10, s. 225 (1).
4. The Ministry's toll-free telephone number for making complaints about homes and its hours of service. O. Reg. 79/10, s. 225 (1).
5. Together with the explanation required under clause 79 (3) (d) of the Act, the name and contact information of the Director to whom a mandatory report shall be made under section 24 of the Act. O. Reg. 79/10, s. 225 (1).

Findings/Faits saillants :

1. The fundamental principle, Section 1 of the LTCHA, was not posted at the time of the inspection. [s. 225. (1) 1.]

2. The Ministry's toll-free number for making complaints about the home, and the hours of service were not posted at the time of the inspection. [s. 225. (1) 4.]

Issued on this 11th day of March, 2014

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

Pat Powers #157