Ontario

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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
December 15 and 16, 2010	2010_170_8522_20Dec115001	Critical Incident L-01798

Licensee/Titulaire
The Governing Council of the Salvation Army in Canada, 369 Frederick Street, Kitchener, ON, N2H 2P1

Long-Term Care Home/Foyer de soins de longue durée
A R Goudie Eventide Home (Salvation Army), 369 Frederick Street, Kitchener, ON, N2H 2P1

Name of Inspector/Nom de l'inspecteur
Dianne Wilbee #170

Inspection Summary/Sommaire d'inspection

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

During the course of the inspection, the inspector spoke with: Executive Director, Director of Nursing, Resident, Personal Support Workers (2), Housekeeping staff (1).

During the course of the inspection, the inspector: Reviewed Abuse Policy and Procedure (Home and The Salvation Army Canada and Bermuda Territory), reviewed resident record, reviewed staff statements, reviewed independent investigation minutes, interviewed residents (2), spoke with Waterloo-Wellington Elder Abuse Response officer.

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

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN
2 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, 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.

Findings:

The home's policy was not complied with as follows:

1. **A staff member did not report an allegation of resident abuse to their immediate supervisor or to management.**
2. **A staff member did not intervene or report an incident of a staff member neglecting to assist a resident with a care need.**

Inspector ID #:	170

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 requirements of the abuse policy, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6(3) The licensee shall ensure that the plan of care covers all aspects of care, including medical, nursing, personal support, nutritional, dietary, recreational, social, restorative, religious and spiritual care.

Findings:

An identified resident's plan of care did not include the following:

1. **The relationship challenges between the resident and a co-resident.**
2. **Behaviours specific to concerns identified by staff with triggers and interventions specific to all behaviours.**
3. **Program/activation involvement with consideration to resident's reluctance to participate.**
4. **The spiritual support provided the resident post an incident.**
5. **The resident's cognitive status is not appropriately identified.**

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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 requirements for the plan of care, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. Dianne Gilbert
Title: **Date:**	**Date of Report:** December 24, 2010