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

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
Oct 28, 2019	2019_819524_0008	019832-19	Critical Incident System

Licensee/Titulaire de permis

S & R Nursing Homes Ltd.
265 North Front Street Suite 200 SARNIA ON N7T 7X1

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

Afton Park Place Long Term Care Community
1200 Afton Drive SARNIA ON N7S 6L6

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

INA REYNOLDS (524)

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): October 24 and 25, 2019.

The following Critical Incident report was inspected during this inspection:
Log #019832-19 / CI #2872-000021-19 related to allegations of sexual abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Resident Care, the Assistant Manager of Resident Care, a Registered Practical Nurse, a Personal Support Worker, a Housekeeping Aide and residents.

The inspector(s) also observed resident care provisions, resident and staff interactions, reviewed a resident's clinical record, the home's investigation notes and relevant policies
and procedures related to this inspection.

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

During the course of this inspection, Non-Compliances were issued.

2 WN(s)
1 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with. Specifically, staff failed to comply with the home’s “Resident Abuse and Neglect” policy (last revised May 21, 2019).

A review of a Critical Incident System (CIS) report reported to the Ministry of Long-Term Care Infoline on a specific date, documented an alleged incident of staff to resident abuse. The CIS showed that a resident’s family member had voiced a concern to a personal support worker (PSW) on an identified date, regarding a staff member. The PSW reported the concern to Registered Practical Nurse (RPN) #106 on their shift.

Review of the home’s investigation notes and the critical incident documented an email sent by RPN #106 on a specific date, describing the allegation of abuse to Manager of Resident Care (MRC) #101. The email was not reviewed by MRC #101 until the next day. MRC #101 initiated an investigation immediately upon hearing of the incident and appropriate actions were taken by the home in response to the incident.

Review of the home’s policy titled "Resident Abuse and Neglect" #ADMIN 08-05 with revised date May 21, 2019, directed staff under procedure to “immediately report (verbally) any suspected or witnessed abuse to the Administrator, Manager of Resident Care or delegate.”

In an interview, Manager of Resident Care #101 acknowledged that RPN #106 had not complied with the home’s policy and the incident had not been reported in a timely manner. MRC #101 said that the expectation was that staff report immediately and verbally if they suspect any abuse. MRC #101 said that an email was not sufficient, and the allegation should have been reported to the registered nurse on shift who then called it in to management. [s. 20. (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 the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident: (ii) names of any staff members or other persons who were present at or discovered the incident.

A review of a Critical Incident System report (CIS) submitted by the home to the Ministry of Long-Term Care on a specific date, documented an alleged incident of staff to resident abuse. The CIS showed that a resident's family had voiced a concern to a personal support worker (PSW) on a identified date, regarding a staff member.

The Manager of Resident Care #101, upon hearing of the incident had immediately initiated an investigation and the staff member involved in the incident was identified and suspended. However, a review of the CIS report amended on a specific date and time, showed that the staff member involved in the alleged abuse of the resident was not named in the report.

In an interview, Administrator #100 and Manager of Resident Care #101 verified that the staff member's name had not appeared in the incident report and acknowledged that they should have been included. [s. 104. (1) 2.]

Issued on this 29th day of October, 2019

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

Original report signed by the inspector.