Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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 10, 2020	2020_821640_0003	021562-19, 023268-19	Complaint

Licensee/Titulaire de permis

488491 Ontario Inc.
c/o Jarlette Health Services 711 Yonge Street MIDLAND ON L4R 2E1

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

Avalon Retirement Centre
355 Broadway Avenue ORANGEVILLE ON L9W 3Y3

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

HEATHER PRESTON (640)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 7 and 9, 2020.

During the course of the inspection, the LTCH Inspector toured the home, observed the provision of care, conducted interviews, reviewed clinical records, investigative notes and policy and procedure.

The following Complaint Inspection report was reviewed:
eCorrespondence 149-2019-420, Log #023268-19 regarding a concern about alleged verbal abuse

The following Critical Incident (CI) report was reviewed:

Log #021562-19 regarding an allegation of verbal abuse

During the course of the inspection, the inspector(s) spoke with family members, residents, personal support workers, Registered Practical Nurses, Registered Nurses, Housekeeping, Director of Care and the Administrator.

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.

- **1 WN(s)**
- **0 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. 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).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident was treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected their dignity.

The licensee submitted a Critical Incident (CI) report to the Ministry of Long-Term Care (MOLTC) related to the receipt of an anonymous letter informing the leadership of the home, that staff member #107 had been rude and disrespectful to several residents on several occasions. The letter did not contain specific dates of the incidents.

The MOLTC received a complaint from one of the substitute-decision makers of one of the residents, after the home had notified them of the initial allegations included in the note.

The licensee's policy "Resident Rights, Care and Services - Residents Bill of Rights, version 1 with an effective date of July 21, 2015, directed that the Residents' Bill of Rights were to be fully respected and promoted. All staff were to understand that the home was the resident's home and a place for them to live with dignity and have their physical, psychological, social spiritual and cultural needs met. All staff were to fully respect the resident's rights.

Staff members #103, #104, #106, #108, #109 and #110 said that they had observed staff member #107 talking rudely and disrespectfully to residents #001, #002, #003, #004, #005, #006 and #007 at times. One resident had been ignored by staff member #107 when they had made a request to use some equipment.

Staff member #107 acknowledged that their actions were rude and disrespectful and did not respect the resident's dignity.

The Long-Term Care Homes (LTCH) Inspector attempted to interview the residents involved however, they did not have recall.

The home conducted an immediate investigation and determined that staff member #107 had not been respectful to seven residents. The home took action related to the outcome of their investigation.

The licensee failed to ensure that all residents were treated with respect and dignity. [s. 3. (1) 1.]

Issued on this 13th day of January, 2020

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

Original report signed by the inspector.