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
Oct 20, 2020	2020_638542_0021	015550-20	Complaint

Licensee/Titulaire de permis

North Shore Health Network
525 Causley Street P.O. Box 970 BLIND RIVER ON P0R 1B0

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

North Shore Health Network - LTC Unit
525 Causley Street P.O. Box 970 BLIND RIVER ON P0R 1B0

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

JENNIFER LAURICELLA (542)

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): October 13 - 14, 2020.

One intake related to personal care of a resident was inspected.

An "Other" Inspection #2020_638542_0022 was conducted concurrently with this Inspection.

During the course of the inspection, the inspector(s) spoke with the Nurse Manager, Registered Practical Nurse (RPN), Personal Support Worker (PSWs) and residents.

The Inspector observed the overall provision of care provided to the residents and reviewed relevant health care records.

The following Inspection Protocols were used during this inspection:
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 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. 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that, (a) every alleged, suspected or witnessed incident of the following that the licensee knew of, or that was reported to the licensee, was 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; (b) appropriate action was taken in response to every such incident; and (c) any requirements that were provided for in the regulation for investigating and responding as required under clauses (a) and (b) were complied with.

Inspector overheard a resident request medication from an RPN. The Inspector overheard the RPN speak inappropriately to the resident.

The Inspector informed the Nurse Manager of the incident who indicated that they would “take care of it”. Near the end of their shift, the Inspector inquired with the Nurse Manager if they had investigated the incident that occurred earlier in the shift. The Nurse Manager indicated that they had not.

The Inspector, the resident and the Nurse Manager met in a confidential area. The resident stated that the RPN made them feel “tiny” and that they no longer trusted the RPN. The resident further stated that they felt that the RPN did not like them.

On the same day, the Nurse Manager acknowledged that they failed to immediately start an investigation and complete all other requirements in the regulations for investigating and responding to any alleged, suspected or witnessed incident of abuse.

Sources: Observations, Interviews with the resident and the Nurse Manager. [s. 23. (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 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; (b) appropriate action is taken in response to every such incident; and (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)., to be implemented voluntarily.

Issued on this 27th day of October, 2020

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

Original report signed by the inspector.