

Ministry of Long-Term Care

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

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Amended Public Report Cover Sheet (A2)

Amended Report Issue Date: September 26, 2024

Original Report Issue Date: August 2, 2024

Inspection Number: 2024-1279-0004 (A2)

Inspection Type:

Complaint

Critical Incident

Licensee: MacGowan Nursing Homes Ltd.

Long Term Care Home and City: Braemar Retirement Centre, Wingham

AMENDED INSPECTION SUMMARY

This report has been amended to:

CO #001 has been rescinded as per Director review, DREV-0026

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 3-5, 8-11, 2024

The following intake(s) were inspected:

- Intake: #00117208 - Prevention of Abuse and Neglect
- Intake: #00117732 - Falls Prevention and Management
- Intake: #00119202 - complaint related to Falls Prevention and Management and Nutritional care.

The following **Inspection Protocols** were used during this inspection:

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Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management
Admission, Absences and Discharge

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to protect a resident from abuse by another resident.

Rationale and Summary:

For the purposes of the definition of “abuse” “sexual abuse” means,

Any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff

A Restorative Aide witnessed a resident inappropriately touching a co-resident. They immediately removed the co-resident from the area, taking them to their

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room. Restorative Aide reported the incident to an RN.

Sources: Investigation notes, resident's progress notes, surveillance video, interview with restorative aide, RN and DOC.

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance

The licensee has failed to ensure the home's zero tolerance of abuse and neglect policy was followed after sexual abuse was witnessed and reported.

Rationale and Summary:

The Zero Tolerance of Abuse and Neglect policy dated January 2023, stated that if a staff member or volunteer becomes aware of or suspects potential or actual abuse or neglect of a resident, be it by a staff member, volunteer, family member, co-worker, student, or another resident the following steps must be taken.

Charge Nurse on duty:

1. Assess and evaluate injuries and document each shift for a minimum of 72 hours post incident,
2. Based upon the incident, determine if a more in-depth head to toe assessment is required,
3. Notify the family/representative/substitute decision maker of an instance of alleged abuse,
4. Obtain statements from all witnesses and document his/her account of the incident,
5. Remind witness of the need to maintain confidentiality of the incident as well as both the resident and the alleged abuser,
6. Notify Physician/Nurse Practitioner.

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A resident was witnessed touching a co-resident inappropriately. The incident was reported to RN who failed to follow the home's zero tolerance of abuse and neglect policy.

The RN's failure to follow the abuse policy made it challenging to know the impact to the resident and what follow up was required.

Sources: Progress notes for residents, Zero Tolerance of Abuse and Neglect policy (revised January 2023), and interviews with RN and other staff.

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (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: 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.

The licensee failed to ensure that when staff had reasonable grounds to suspect resident to resident sexual abuse had occurred, that they immediately reported the suspicion and the information upon which it was based to the Director. Pursuant to s. 154 (3), the licensee was vicariously liable for staff members failing to comply with subsection 28 (1).

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Rationale and Summary:

A Restorative Aide witnessed a resident inappropriately touching a co-resident. The Restorative Aide reported the incident to an RN who failed to report the incident to the manager on duty.

The DOC received an email the next morning and reported the alleged abuse to the Director and started an investigation.

Failure to immediately report concerns delayed the home's response and increased the risk of a similar incident happening to another resident. The delayed reporting may have delayed the Director in responding to the incident.

Sources: CIS report, written warning for RN and, interviews with RN and DOC.

(A2) Appeal/DREV #: DREV-0026

The following order(s) has been rescinded: CO #001

COMPLIANCE ORDER CO #001 Requirements on licensee before discharging a resident.

Non-compliance with: O. Reg. 246/22, s. 161 (2)

Requirements on licensee before discharging a resident

s. 161 (2) Before discharging a resident under subsection 157 (1), the licensee shall,

(a) ensure that alternatives to discharge have been considered and, where appropriate, tried.

(b) in collaboration with the appropriate placement coordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident.

(c) ensure the resident and the resident's substitute decision-maker, if any, and any

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person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that their wishes are taken into consideration; and

(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

REVIEW/APPEAL INFORMATION**TAKE NOTICE**

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

- (a) the portions of the order or AMP in respect of which the review is requested;
- (b) any submissions that the licensee wishes the Director to consider; and
- (c) an address for service for the licensee.

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The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- (a) registered mail, is deemed to be made on the fifth day after the day of mailing
- (b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
- (c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- (a) An order made by the Director under sections 155 to 159 of the Act.
- (b) An AMP issued by the Director under section 158 of the Act.
- (c) The Director's review decision, issued under section 169 of the Act, with respect

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to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.