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
Mar 18, 2022	2021_815623_0021	007478-21, 007577-21, 009327-21, 010708-21, 011982-21, 015430-21	Critical Incident System

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue Woodstock ON N4S 3V9

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

Caressant Care on McLaughlin Road
114 McLaughlin Road Lindsay ON K9V 6L1

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

SARAH GILLIS (623)

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 21, 22, 25-29, November 1-5, 9 and 10, 2021

The following intakes were inspected concurrently:
Log #007478-21 for a Critical incident Report for an allegation of staff to resident neglect
Log #007577-21 for a Critical Incident Report for an allegation of staff to resident neglect
Log #009327-21 for a Critical Incident Report for a fall resulting in injury
Log #010708-21 for a Critical Incident Report for a fall resulting in injury
Log #011982-21 for a Critical Incident Report for an allegation of staff to resident abuse
Log #015430-21 for a Critical Incident Report for an allegation of staff to resident abuse

Non-compliance identified in complaint inspection 2021-815623-0020 - related to a Complaint/CIR for s.23 (2) will be reflected in this report along with similar findings.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Occupational Therapist (OT), Housekeepers (HSKP), Administrative Assistant (AA), Ward Clerk, Clinical Practice Lead - Caressant Care, Regional Director of Operations - Caressant Care, residents and families.

The Inspector also reviewed the licensee's internal records, resident health care records, housekeeping services, applicable policies, observed Infection Prevention and Control practices, the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

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

8 WN(s)
8 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A Critical Incident Report (CIR) was submitted to the Director for an allegation of neglect, when resident #003 was discovered to have been left to toilet for an extensive length of time and the call bell was out of the resident's reach.

Review of the written care plan indicated resident #003 was totally dependent on two staff for toileting and personal care. The care plan also indicated that resident #003 was to be turned and repositioned on a schedule, when in bed.

During an interview resident #003 indicated they had been assisted to toilet by two staff and they did not return. RN #126 discovered resident #003 several hours later. The resident was unable to call for assistance as the call bell was out of reach for the resident.

During an interview PSW #104 indicated that when resident #003 is assisted to toilet and staff are to ensure that the call bell is within reach. Staff are supposed to check back every 15 minutes to see if the resident is finished. PSW #104 indicated that resident #003 would be unable to reposition without staff assistance.

When the plan of care for resident #003 was not followed, the resident was at risk for impaired skin integrity.

Source: CIR, resident care plan, staff interview, resident interview. [s. 6. (7)]

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 by ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home is equipped with a resident-staff communication system that can be easily seen, accessed and used by residents, staff and visitor at all times.

A Critical Incident Report (CIR) was submitted to the Director for an allegation of neglect, when resident #003 was discovered to have been left to toilet for approximately three hours, and the call bell was not within reach of the resident.

Review of the CIR indicated that when RN #126 discovered resident #003, the call bell was observed to be on the floor beside the bed.

During an interview resident #003 indicated that PSW's had assisted them to toilet and then left the room, the call bell was on the floor beside the bed and the resident was unable to reach the call bell. The staff did not return, RN #126 came to the room after several hours. The resident indicated they were in a lot of pain after being left for that long.

The Executive Director confirmed the expectation of the home is a call bell will be within reach of the resident at all times.

When the licensee failed to ensure that a call bell was within reach of resident #003 when they were toileting, the resident was unable to call for assistance for several hours resulting in pain and distress.

Source: CIR, resident interview, staff interview. [s. 17. (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 by ensuring that the home is equipped with a resident-staff communication system that can be easily seen, accessed and used by residents, staff and visitor at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect resident #006 and others from abuse by PSW #115.

Resident #006 reported to RPN #119 that PSW #115 allegedly propositioned and touched them in an inappropriate manner. A Critical Incident Report was submitted to the Director.

During an interview resident #006 indicated that PSW #115 entered their room three times. The resident indicated the PSW touched them in an inappropriate manner and made inappropriate suggestions to them. Resident #006 reported the incident to RPN #119 immediately after. Resident #006 indicated they were frightened and did not feel safe.

During an interview RPN #119 indicated that resident #006 reported an allegation of inappropriate touching by PSW #115 had occurred. RPN #119 indicated that resident #006 pointed out PSW #115 and identified them as having been the staff member involved. PSW #115 was asked to leave and the incident was reported to the Manager on Call RN #103.

The ED indicated that once becoming aware of the alleged incident the following day, the Director was notified, the police were notified, and an investigation commenced. The ED indicated that PSW #115 had been employed in the home through a nursing agency and the PSW no longer worked in the home, the ED was unable to interview PSW #115 as part of the investigation.

The licensee failed to protect resident #006 from abuse resulting in emotional trauma when PSW #115 allegedly propositioned and touched the resident in an inappropriate manner.

Sources: CIR, internal investigation, resident #006 interview, interview with RPN #119 and ED. [s. 19. (1)]

2. The licensee failed to ensure that resident #003 was protected from neglect by staff in the home.

A Critical Incident Report (CIR) was submitted to the Director for an allegation of neglect, when resident #003 was discovered to have been left for several hours and the call bell was out of the resident's reach.

Review of the CIR indicated that RN #126 discovered resident #003 in their room, the resident was crying and uncomfortable. The resident had been placed to toilet several hours prior, by PSW #127 and #128, they did not return. The call bell was on the floor beside the bed and out of resident #003's reach.

During an interview resident #003 indicated at the time of the incident they were a new to the home and had been placed on isolation precautions. The resident recalled the PSW's toileting them and they did not return. The resident indicated the call bell was on the floor and they were unable to reach it to call for assistance. No one entered the room to check on them until the RN arrived several hours later. The resident indicated by that time they were in pain and upset at having been left.

Resident #003 had a history of a healed pressure wound. Documentation indicated a closed stage 3 wound prior to the incident. A skin assessment two days after the incident indicated the wound was reopening.

During an interview RPN #106 indicated they had completed skin assessments for resident #003. An assessment by RN #126 immediately following the extended period of time left toileting, identified skin discoloration. The RPN indicated that two days following the incident, the closed stage 3 wound had reopened. RPN #106 indicated pressure to the area for an extended period of time could have contributed to the wound reopening.

During an interview the Executive Director (ED) indicated they were not employed in the home at the time of CIR and the staff involved in the incident were unavailable at the time of inspection. The ED indicated the expectation is that all resident are protected from neglect by staff in the home.

The licensee failed to protect resident #003 from neglect when the resident was left to toilet for an extended period of time with no way to call for assistance, and staff did not check on the resident. This resulted in physical pain, emotional upset and the reopening

of a healed wound.

Source: CIR, internal investigation, skin and wound records, interview with resident #003, RPN and ED. [s. 19. (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 by protecting residents from abuse by anyone and ensuring that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #4: 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. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the results of the abuse investigation were reported to the Director.

A CIR was reported to the Director for an allegation of abuse by PSW #115 towards resident #006. The incident was reported to the action line the following day.

Review of the licensee's internal investigation indicated that there were no updates to the CIR after the initial report. The Director was not notified of the outcome of the licensee's investigation.

During an interview the ED indicated that they did not update the CIR with the outcome of the abuse investigation. The ED indicated this was their responsibility and they did not do it.

The licensee failed to ensure that the results of the abuse investigation were reported to the Director.

Sources: CIR, internal records, ED interview. [s. 23. (2)]

2. The licensee failed to ensure that the results of the abuse investigation were reported to the Director.

A CIR was reported to the Director for an allegation of abuse towards resident #007. The incident was called to the Action Line the following day and the CIR was submitted four days later.

Review of the licensee's internal investigation indicated the outcome of the licensee's internal investigation was not provided in the CIR. The Director was not notified of the outcome of the licensee's investigation.

During an interview the ED indicated that they did not update the CIR with the outcome of the alleged abuse investigation. The ED indicated this was their responsibility and they did not do it.

The licensee failed to ensure that the results of the abuse investigation were reported to the Director.

Sources: CIR, internal records, ED interview.

The licensee failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

A Critical Incident Report was submitted to the Director which indicated the Executive Director (ED) had received an email complaint from resident #001's family member indicating an allegation of abuse. The CIR indicated an investigation was pending, and the ED would amend the CIR with the outcome of the investigation.

Review of the CIR indicated there were no amendments to the report after the initial submission. During the inspection the licensee was unable to provide information related

to the investigation or outcome of the investigation for the allegation of abuse towards resident #001.

The licensee failed to ensure the results of the abuse investigation for allegations related to resident #001, were reported to the Director.

Source: CIR, record review, staff interviews. [s. 23. (2)]

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 by ensuring that the results of the abuse investigation are reported to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident had occurred or may occur, immediately report the suspicion and

the information upon which it was based to the Director.

On a specified date RN #103 was the manager on call. RPN #119 contacted RN #103 to inform them resident #006 had reported an allegation that PSW #115 had touched the resident in an inappropriate manner. RPN #119 also informed RN #125 who was present in the home at the time of the incident.

Review of the Critical Incident Report indicated that a report was not made to the Director until the following day.

During an interview RPN #119 indicated that RN #103 instructed them to send PSW #115 home and complete an internal incident report. The RN did not ask RPN #119 to notify the Director.

During an interview the Executive Director (ED) #100 indicated they became aware of the incident the following day when the resident reported the allegation to another PSW, who then reported it to the ED. RN #103 was in the position of Acting Director of Care at the time of the incident, they recalled receiving a call after hours from RPN #119 but could not recall the conversation. The ED indicated that once they became aware, they called the action line to report to the Director but this was not until the day following the incident. The ED indicated the expectation of the home is that the RN Manager on call should have immediately reported the allegation to the Director or instructed RPN #119 to do so.

The licensee failed to immediately inform the Director of an allegation of abuse by PSW #115 towards resident #006.

Sources: CIR, staff interviews. [s. 24. (1)]

2. The licensee failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

On a specified date RN #116 was made aware that resident #007 had reported an allegation of physical abuse by PSW #117 and #118. Documentation in the resident’s medical records by RN #116, indicated that resident #007’s family attended the home and reported the alleged incident to RN #116.

Review of the Critical Incident Report indicated that a report was not made to the Director until the following day when the Executive Director (ED) notified the action line once becoming aware of the allegation.

During an interview the ED indicated they became aware of the incident the when the family members of resident #007 met with the ED and reported the allegations. The ED indicated that once they became aware, they called the action line to report to the Director, but this was not until the day following the incident. The ED indicated the expectation of the home is that the RN in charge at the time of the incident should have immediately reported the allegation to the Director or notified the Manager on call to do so. The ED indicated that RN #116 was employed in the home through a nursing agency and had not received education related to Duty to Report and was unaware of the reporting requirements.

The licensee failed to immediately inform the Director of an allegation of abuse by PSW #117 and #118 towards resident #007.

Sources: CIR, resident record review, staff interviews. [s. 24. (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 by ensuring that the person who has reasonable grounds to suspect that abuse of a resident has occurred or may occur, immediately report the suspicion and the information upon which it was based, to the Director, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include police record checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2); 2015, c. 30, s. 24 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that police record checks were conducted prior to hiring a staff member and/or accepting a volunteer who is 18 years of age or older.

Review of the internal records for PSW #115 indicated they were hired as a PSW to work in the home through an Agency. The date of hire was unclear based on the information available. A police record check that was provided, identified a positive vulnerable sector screening but was missing the details of the positive result.

During an interview the ED indicated that the licensee had not obtained the qualifications and police record checks for staff hired through the agency. The ED indicated that when the allegation of abuse incident involving PSW #115 was reported, the ED requested these records from the Agency. This was the first time the ED became aware that PSW #115 did not have a police record check on file in the home. The ED also indicated that Agency staff who had been hired to work in the home were not identified by name, just as “Agency PSW” so they could not determine when PSW #115 began working in the home or specific dates/shifts that the PSW had worked in the home. The ED confirmed that the home also did not require new staff or volunteers hired, to provide a signed declaration disclosing any reportable matters as per O. Reg 79/10 s.215 (8) 1.

When the licensee failed to verify that police record checks were conducted prior to hiring agency staff, and to obtain a signed declaration disclosing any reportable matters with respect to the period since the date of their last police record check under O.Reg. 79/10 s. 215 (8) 1, they placed vulnerable residents at risk.

Source: staff personal files, interview with ED. [s. 75. (2)]

2. The licensee failed to ensure that police record checks were conducted prior to hiring a staff member and/or accepting a volunteer who is 18 years of age or older.

Review of the internal records for PSW #117 and PSW #118, indicated they were hired as PSW’s to work in the home through Nursing Agencies. A police records check was obtained for PSW #117 from the agency, following the allegation of abuse. The police records check that was provided did not include a vulnerable sector screening. A police records check for PSW #118 was also obtained from the nursing Agency following the allegation of abuse.

During an interview the ED indicated that the licensee had not obtained the qualifications and police record checks for staff hired through the agency, including PSW #117 and #118 until after the allegations of abuse were reported. The ED confirmed that the home also did not require new staff or volunteers hired to provide a signed declaration disclosing any reportable matters as per O. Reg 79/10 s.215 (8) 1.

When the licensee failed to verify that police record checks were conducted prior to hiring staff, and failed to obtain a signed declaration disclosing any reportable matters with respect to the period since the date of their last police record check under O.Reg. 79/10 s. 215 (8) 1, they placed vulnerable residents at risk.

Source: staff personal files, interview with ED. [s. 75. (2)]

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 by ensuring that police records checks are conducted prior to hiring a staff member and/or accepting a volunteer who is 18 years of age or older, or obtaining a signed declaration disclosing reportable matters as per O.Reg 79/10 s. 215 (8) 1, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff received training on the homes policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities.

Review of the licensee's internal records for PSW #115 revealed that there was no evidence of the PSW having received any mandatory training since they were hired in the home.

During an interview the ED indicated that they were not aware of any training for new staff hired in the home in 2021. The ED indicated that there was no record of agency staff having received any training in the online Surge learning system for the home.

When the licensee failed to ensure new staff including those hired through an Agency, received training related to zero tolerance of abuse and neglect of a resident, within one week of being hired in the home, they placed the residents at risk of being abused.

The licensee failed to ensure that staff received training related to zero tolerance of abuse and neglect, prior to performing their responsibilities or during a pandemic, within one week of when they began performing their responsibilities in the home as per O. Reg 79/10 s.218 (2) (a).

Sources: staff personal files, Surge learning, interview with ED. [s. 76. (2) 3.]

2. Review of the licensee's internal records for PSW #117, #118 and RN #116 revealed that there was no evidence of the PSW's and RN having received any mandatory training since they were hired in the home.

During an interview the ED indicated that they were not aware of any training for new staff hired in the home in 2021. The ED indicated that there was no record of agency staff having received any training in the online Surge learning system for the home.

When the licensee failed to ensure new staff including those hired through an Agency, received training related to zero tolerance of abuse and neglect of a resident, within one week of being hired in the home, they placed the residents at risk of being abused.

The licensee failed to ensure that staff received training related to zero tolerance of abuse and neglect, prior to performing their responsibilities or during a pandemic, within one week of when they began performing their responsibilities in the home as per O. Reg 79/10 s.218 (2) (a).

Sources: staff personal files, Surge learning, interview with ED. [s. 76. (2) 3.]

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 by ensuring that staff receive training on the homes policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to ensure the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

On a specified date resident #006 reported an allegation of abuse by PSW #115.

Review of the licensee's internal investigation revealed that the police were not notified of the allegation of abuse, until the following afternoon.

During an interview RPN #119 indicated that when resident #006 reported the allegation of abuse, they did not contact the police. RPN #119 indicated when they notified the RN Manager on call, they were not asked to notify the police, they were only instructed to send PSW #115 home.

During an interview the ED indicated that once they became aware of the allegation of abuse by PSW #115 towards resident #006, they contacted the police to report the allegation. The ED indicated the expectation of the home is that the police would be contacted immediately when there is an alleged, suspected or witnessed incident of abuse towards a resident.

Source: CIR, internal records, staff interviews. [s. 98.]

2. The licensee failed to ensure the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

On a specified date resident #007 reported an allegation of abuse by PSW #117 and #118 which included being cared for in a rough manner and slapped by the PSW. The

resident also alleged that the PSW's asked the resident for money.

Review of the licensee's internal investigation revealed that the police were not notified of the allegation of abuse, until the following afternoon.

During an interview the ED indicated that once they became aware of the allegation of abuse by PSW #117 and #118 towards resident #007, they contacted the police to report the allegation and the police attended the home to gather information. The ED indicated the expectation of the home is that the police would be contacted immediately when there is an alleged, suspected or witnessed incident of abuse towards a resident.

Source: CIR, internal records, staff interviews. [s. 98.]

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 by ensuring that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse of neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

Issued on this 25th day of March, 2022

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

Original report signed by the inspector.