Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 2, 2015	2015_200148_0011	O-001839-15	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

CARLINGVIEW MANOR
2330 CARLING AVENUE OTTAWA ON K2B 7H1

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

AMANDA NIXON (148)

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): March 20, 2015, on site.

This inspection included Critical Incident report #2420-000019-15.

During the course of the inspection, the inspector(s) spoke with the home's Director of Care (DOC), Staff Development Coordinator, Registered and non-registered nursing staff and Resident #1.

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	Legendé 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 policy to promote zero tolerance of abuse and neglect of residents, is compiled with.

A Critical Incident report was received by the Director on March 17, 2015. The report indicated that on a specified date, Resident #1 had shared with staff information related to an alleged sexual abuse that may have occurred the day before. Upon further discussion with the home's DOC, it was determined that during the night shift of a specified date, Resident #1 described to the Registered Practical Nurse and Registered Nurse (RN) on duty about a staff member touching him/her inappropriately during care. The staff wrote a statement of the events as described by the resident and placed the statement in the DOC's mailbox. The DOC retrieved and read the letter on the afternoon following the night shift. Upon reviewing the information the home's senior management took immediate action and began an investigation into the alleged incident.

The home's policy to promote zero tolerance of abuse and neglect of residents, LP-C-20-ON Revised September 2014, indicates the following under mandatory internal reporting: "Any staff member or person, who becomes aware of and/or has reasonable grounds to suspect abuse or neglect of a resident must immediately report that suspicion and the information on which it is based to the Executive Director (ED) of the home, or if unavailable to the most senior supervisor on shift at the time. The person reporting the suspected abuse or neglect must follow the home's reporting requirements to ensure that the information is provided to the ED immediately. "

Inspector #148 spoke with the home's DOC who indicated that staff with reasonable grounds to suspect abuse are to immediately report to the ED or herself. If the information is obtained at a time outside of regular business hours that staff member is to place a phone call to the ED or herself with the information. The home's DOC acknowledged that the registered nursing staff, including the RN who was a supervisory staff member, did not follow the policy related to internal reporting, in this instance. [s. 20. (1)]

Issued on this 2nd day of April, 2015

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

Original report signed by the inspector.