Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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
Sep 5, 2019	2019_793743_0012	006355-19, 007498-19, 014441-19	Critical Incident System

Licensee/Titulaire de permis

Collingwood Nursing Home Limited
250 Campbell Street COLLINGWOOD ON L9Y 4J9

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

Collingwood Nursing Home
250 Campbell Street COLLINGWOOD ON L9Y 4J9

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

KIYOMI KORNETSKY (743)

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): August 22-23, and 26-28, 2019.

The following intakes were completed in this critical incident inspection:
Log #007498-19 related to a resident's attempted suicide.
Log #006355-19/ Order follow up related to staffing from inspection #2019_781729_0002.
Log #014441-19 related to staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses, Personal Support Workers, Ward Clerk and the Business Office Manager.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

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)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #001	2019_781729_0002	743

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. 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 residents from abuse by anyone.

For the purposes of the definition of "abuse" in subsection 2(2) of the Act, "physical abuse" means the use of physical force by anyone other than a resident that causes physical injury or pain.

A Critical incident was submitted to the Ministry of Long-Term Care (MLTC) related to the alleged physical abuse of resident #003.

Personal Support Worker (PSW) #102 said they observed PSW #107 feeding resident #003. They noted that resident #003 was grabbing for items on the table and PSW #107 proceeded to smack resident #003. PSW #102 documented that they observed and heard the smack.

Video footage from the incident was reviewed. On a specific date at a specific time, PSW #107 was sitting on the left side of resident #003 while feeding them. Resident #003 was sitting in their wheelchair and reached to place their left hand on the table. PSW #107 responded by hitting the resident on their upper extremity four times. The resident then reached towards the table and PSW #107 pushed the resident's upper extremity. A few minutes later, resident #003 was reaching towards the right side of the table when PSW #107 struck them.

The Administrator #105 said the resident was not reaching towards PSW #107, nor were they acting in a manner that would require the PSW to protect themselves. Additionally, when PSW #107 struck the resident, the resident was reaching away from PSW #107.

The licensee failed to ensure that resident #003 was protected from physical abuse, when PSW #107 was observed striking resident #003. [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 to ensure that residents are protected from abuse by anyone, to be implemented voluntarily.

Issued on this 17th day of September, 2019

[redacted]

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

Original report signed by the inspector.