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
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
Jul 28, 2015	2015_416515_0019	014802-15	Critical Incident System

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF LONDON
c/o Dearness Home for Senior Citizens 710 Southdale Road East LONDON ON N6E 1R8

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

DEARNESS HOME FOR SENIOR CITIZENS
710 SOUTHDALE ROAD EAST LONDON ON N6E 1R8

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

RAE MARTIN (515)

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): July 17, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care, Labour Relations and Intake Administrator, Manager of Community Life, a Registered Nurse, two Registered Practical Nurses and a resident.

The inspector also toured an identified home area, observed residents, resident-staff interactions and posting of required information. The health care record and plan of care for an identified resident was reviewed, as well as the home's internal investigation notes, education records and relevant policies and procedures.

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 written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A review of the home's policy entitled Resident Abuse - Staff to Resident dated March 2013, revealed the procedure directs all staff to immediately report (verbally) any suspected or witnessed abuse to the Administrator, Director of Care, or their designate. The Administrator, Director of Care, or their designate must report the incident as required by provincial legislation to the Ministry of Health and Long-Term Care (MOHLTC) Director through the Critical Incident Reporting System/after hours pager.

On an identified date, the Acting Director of Care (ADOC) and current Administrator became aware of an alleged incident that occurred on a specified date 16 months prior, but had not been reported at that time to the MOHLTC Director, in accordance with the legislation and the home's policy. The ADOC immediately submitted a Critical Incident Report to the MOHLTC regarding this incident.

A review of the home's internal communication documents revealed a staff member informed his/her manager by email on an identified date that a resident discussed an alleged incident with that staff member. The manager forwarded the email to the Manager on Call, Director of Care and the Administrator at that time.

In an interview, the current Administrator acknowledged that she had contacted the previous Administrator to inquire if the incident had been reported to the MOHLTC Director and verified that the incident had not been reported.

A review of the Long-Term Care Homes Critical Incident System revealed the incident was not reported to the MOHLTC.

The Administrator confirmed the home's expectation is that the policy that promotes zero tolerance of abuse and neglect of residents is complied with. [s. 20. (1)]

Issued on this 28th day of July, 2015

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

Original report signed by the inspector.