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
Jan 29, 2020	2020_654618_0002	020982-19, 022891-19, 023493-19	Critical Incident System

Licensee/Titulaire de permis

Slovenian Linden Foundation
52 Neilson Drive ETOBICOKE ON M9C 1V7

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

Dom Lipa
52 Neilson Drive ETOBICOKE ON M9C 1V7

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

CECILIA FULTON (618)

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): January 17, 20, 21, 2020.

The following Critical Incident System (CIS) intake logs were inspected during the inspection:
Intake #022891-19, CIS #2794_000013_19, related to Prevention of Abuse.
Intake #023493-19, CIS #2794_000014_19, related to Falls prevention.

Compliance order #001, issued in Order report #2019_654618_0034, was complied during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Staff (RN/RPN), Personal Support Workers (PSW), and Resident's Substitute Decision Makers (SDM).

During the course of the inspection, the inspector conducted record review of relevant resident records, and home policies, investigation records, and documentation related to compliance order under inspection. Observation of residents was conducted during this inspection.

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

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
O.Reg 79/10 s. 36.	CO #001	2019_654618_0034	618

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 :

The Licensee has failed to ensure that Resident #001 was protected from abuse by anyone.

This inspection was initiated in response to CIS report #2794_000013_19, which reported the alleged abuse of resident #001 by PSW #100.

The Licensee became aware of the allegation of abuse in December 2019, when resident #001's SDM reported it to RN #105 in a telephone conversation.

Interviews with RN #105 identified that resident #001's SDM called the unit during an evening shift in December 2019, to report that the day shift PSW #100 had punched resident #001. This had not been reported to RN #105 at shift report, and they went and assessed the resident. RN #105 reported that the resident had no physical signs of the reported assault, and that they were their usual self that evening, and while being assessed and there was no discussion about the allegation.

Interview with resident #001's SDM identified that resident #001 had reported this incident to them in a telephone conversation that evening. The SDM also stated that resident #001 had reported a prior incident involving this staff member, but this had not been reported to the home at the resident's request to their SDM.

The Home conducted an investigation into the allegation which included interviews with the staff involved and the resident. The interview with the resident, revealed that the resident recounted the incident and stated that PSW #100 punched them. The transcript of that interview also revealed that a negative verbal interaction occurred between the resident and staff during this encounter.

The transcript of the interview with PSW #100 revealed that they had had a verbal disagreement with resident #001 pertaining to the cleanliness of the wheelchair, and that PSW #100 put their hand on the resident's chin while brushing the resident's hair. PSW #100 stated that they told the resident they wanted to brush their hair, the resident did not respond, and the staff put their hand on the resident's chin to lift their head. PSW #100 denied hitting the resident.

Interviews with the DOC and the Administrator identified that the PSW #100 demonstrated to them what had occurred. The demonstration depicted the staff member putting their hand on the resident's chin in order to lift the resident's head so that they could brush the resident's hair.

Assessments of the resident by registered staff did not reveal any signs of injury.

Interviews with staff who were familiar with resident #001, including staff #101, 104, 105, 106 and 107, identified a resident who often communicates in a problematic manner, but who they all described as a resident who retains the capacity to communicate effectively and identify persons and places. The approach identified in the resident's plan of care, and by direct care staff is to allow resident to express themselves, and to approach/re-approach in a calm manner.

PSW #100 was not available for interview during this inspection. Review of the home's investigation notes and interviews with the DOC and Administrator confirm that PSW #100 did not engage with resident #001 in a therapeutic manner, and that their actions towards resident #001 were abusive and resulted in harm to the resident.

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 and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

Issued on this 30th day of January, 2020

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

Original report signed by the inspector.