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 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
Jun 14, 2019	2019_702197_0014	016717-18, 017696-18, 027978-18, 030651-18	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Fenelon Court
44 Wychwood Crescent FENELON FALLS ON K0M 1N0

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

JESSICA PATTISON (197)

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): June 5-7 (on-site), 11 (off-site), 2019

The following logs were completed as part of this inspection:
016717-18 - related to an injury to a resident which resulted in a transfer to hospital and significant change in their health status
017696-18 - related to alleged staff to resident neglect
027978-18 - related to alleged staff to resident abuse and neglect
030651-18 - related to the unexpected death of a resident

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care and a resident.

The inspector also reviewed internal investigation files, education records, the licensee's resident non-abuse policy and resident health care records.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
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	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. 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 staff member #103 complied with the home's written policy that promotes zero tolerance of resident abuse and neglect.

The licensee's policy titled "Resident Non-Abuse", last updated March 31, 2019, indicates the following:

Anyone who becomes aware of or suspects abuse or neglect of a Resident must immediately report that information to the Executive Director or, if unavailable, to the most senior supervisor on shift.

On a specified date, the licensee submitted a critical incident report (CIR) indicating that staff member #103 had submitted a written statement to the Director of Care (DOC) on that day, alleging staff to resident abuse and neglect. The statement indicated that three days earlier, staff member #103 witnessed staff member #104 being verbally abusive towards resident #002. Staff member #103 also indicated that staff member #104 refused to provide a specified type of care to three other residents on the same shift.

The investigation notes showed that staff member #103 was asked by the Executive Director (ED) in an interview why they did not come forward right away. Staff member #103 indicated that they did not want to be known as someone who caused trouble. The notes indicated that staff member #103 went on to say that they knew they should have come forward and that's why they put the incident in writing.

During an interview with the ED, they acknowledged that their Resident Non-Abuse policy was not followed by staff member #103. The ED indicated that the importance of immediately reporting resident abuse and neglect was reviewed with the staff member during the investigation process. [s. 20. (1)]

Issued on this 17th day of June, 2019

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

Original report signed by the inspector.