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
Mar 13, 2020	2020_569508_0011	001151-20	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of Niagara
1815 Sir Isaac Brock Way THOROLD ON L2V 4T7

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

Gilmore Lodge
50 Gilmore Road Fort Erie ON L2A 2M1

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

ROSEANNE WESTERN (508)

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 11, 2020.

A Critical Incident related to an allegation of abuse was inspected.

During the course of the inspection, the inspector reviewed resident clinical records and reviewed evidence related to the incident.

During the course of the inspection, the inspector(s) spoke with the Administrator and the Director of Resident Care (DRC).

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

A Critical Incident (CI) report was submitted to the Director in 2020, regarding an allegation of staff to resident abuse.

A review of the CI report indicated that on an identified date, a family member of resident #001 notified the Administrator of an incident that occurred and provided evidence of this occurrence.. The CI report indicated that there was a physical altercation between a staff member and the resident.

During a review of the resident's clinical health record, it was identified that resident #001 was cognitively impaired and exhibited responsive physical behaviours towards staff during care. The resident's plan of care related to their responsive behaviours directed that two (2) staff were to provide care at all times.

On an identified date, PSW staff #103 provided care to resident #001 and a physical altercation occurred between the resident and the staff.

During the home's internal investigation, it was identified that staff #103 had provided care to the resident without another staff member to assist as directed in the plan of care.

It was confirmed during review of the resident's clinical health records, the home's investigative notes and during interview with the Administrator, that care was not provided to resident #001 as specified in the resident's plan of care. [s. 6. (7)]

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 the care set out in the plan of care is provided to residents as specified in the plan., to be implemented voluntarily.

WN #2: 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 ensure that resident #001 was protected from abuse by staff in the home.

A Critical Incident (CI) report was submitted to the Director regarding an allegation of staff to resident abuse that occurred on on an identified date.

A review of the CI report indicated that on an identified date, a family member of resident #001 notified the Administrator of an incident that occurred and provided evidence of this occurrence.. The CI report indicated that there was a physical altercation between a staff member and the resident.

During a review of the resident's clinical health record, it was identified that resident #001 was cognitively impaired and exhibited responsive physical behaviours towards staff during care. The resident's plan of care related to their responsive behaviours directed that two (2) staff were to provide care at all times.

The investigation into the incident was initiated immediately by the Administrator and it was determined after a complete investigation that PSW #103 was abusive towards resident #001.

It was confirmed during review of the investigative notes, interview with the Administrator and review of additional evidence of the incident that resident #001 was not protected from abuse by PSW #103. [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 24th day of March, 2020

[redacted]

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

Original report signed by the inspector.