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
May 25, 2021	2021_796754_0013	002920-21	Critical Incident System

Licensee/Titulaire de permis

Golden Dawn Senior Citizen Home
80 Main Street Lions Head ON N0H 1W0

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

Golden Dawn Nursing Home
80 Main Street Lions Head ON N0H 1W0

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

TAWNIE URBANSKI (754)

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): May 3, 5, 6, 10, 12, 2021.

The following intake was completed during this critical incident inspection:
Log #002920-21, related to an allegation of sexual abuse.

During the course of the inspection, the inspector(s) spoke with the acting Administrator, Director of Care (DOC), Housekeeper, Registered Practical Nurse (RPN), Personal Support Worker's (PSW's) and residents.

The inspector also toured the home, observed resident and staff interactions and meal services, reviewed relevant clinical records, the home's related policies and documentation and completed staff and resident interviews.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that there was in place a hand hygiene program in accordance with evidence-based practices. Specifically, the home's hand hygiene program did not include hand hygiene procedures for residents in relation to meals.

As per Public Health Ontario Just Clean Your Hands Long Term Care Home Implementation Guide, staff are to assist residents to perform hand hygiene before and after meals.

In May 2021, several residents attending the dining room, were not reminded, encouraged or assisted by staff to perform hand hygiene before or after their lunch meal.

A resident said they were never asked or provided assistance to wash or sanitize their hands before or after meals although they felt they should.

Registered staff said that encouraging and helping residents to perform hand hygiene before and after meals was not a regular practice at the home.

Not ensuring residents performed hand hygiene before or after a meal or snack placed staff, essential visitors and residents at potential risk for disease transmission.

Sources: Observations, the home’s Hand Hygiene policy (revised August 2019), and interviews with staff #103 and a resident. [s. 229. (9)]

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 there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of care hand hygiene agents., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to immediately report an allegation of sexual abuse of a resident to the Director in accordance with s. 24 (1) 2 of the Long-Term Care Homes Act. Pursuant to s. 152 (2) the licensee is vicariously liable for staff members failing to comply with s. 24 (1).

A resident alleged that multiple PSW's had touched them inappropriately and in a sexual manner.

The Director of Care (DOC) said they became aware of the alleged incident on the date it allegedly occurred, but did not report it to the Director until 14 days later.

The incident of alleged abuse should have been reported to the Director immediately, but was not reported until 14 days later.

Sources: Critical Incident System Report, Interview with DOC and resident #001. [s. 24. (1)]

Issued on this 26th day of May, 2021

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

Original report signed by the inspector.