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**

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015


## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Apr 12, 2021 | 2021_792659_0008 | 002640-21, 004434-21 | Critical Incident System |

### Licensee/Titulaire de permis

Golden Years Nursing Homes (Cambridge) Inc.
704 Eagle Street North P.O. Box 3277 Cambridge ON N3H 4T3

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

Golden Years Nursing Home
704 Eagle Street North P.O. Box 3277 Cambridge ON N3H 4T3

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

JANETM EVANS (659)

## 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 19, 22, 24 and 25, 2021.**

**The following intakes were completed during this inspection:**
**Log #004434-21, related to a resident to resident altercation with injury.**
**Log #002640-21, related to alleged abuse of a resident by staff.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), a Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), screeners, a housekeeper and a resident.**

**The inspector observed infection prevention and control measures (IPAC), dining, resident to resident and staff to resident interactions, and general care of residents. A review of relevant documentation including but not limited to assessments, plans of care, investigations and policies was completed.**

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

**During the course of this inspection, Non-Compliances were issued.**
- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 :**

1. The licensee failed to protect resident #002 from physical abuse by resident #003.

Ontario Regulation 79/10 states physical abuse is defined, in part, as the use of physical force by a resident that causes physical injury to another resident; (“mauvais traitement d’ordre physique”)

Resident #003 had known verbal and physical responsive behaviours.

Staff witnessed resident #003 hit resident #002, which resulted in an injury and discomfort to resident #002.

The interventions in place to manage resident #003's responsive behaviours were not effective in preventing this incident.

Sources: Critical Incident System Report (CIS), multidisciplinary meeting notes, progress notes, care plan, eMAR and monitoring record and interviews with staff

***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 resident #002 is protected from physical abuse by resident #003, 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 ensure the person who had reasonable grounds to suspect that abuse of a resident by staff had occurred, immediately reported their suspicion and the information upon which it was based to the Director.

On two days over a three week period, a resident alleged abuse by a staff member. The ED was notified of these allegations, however, the incidents were not immediately reported to the Director..

Failure to immediately notify the Director of the alleged incidents did not result in harm to the resident.

Sources: CIS report, home's investigation, risk management, progress notes, plan of care, interviews with resident and staff. [s. 24. (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 the person who has reasonable grounds to suspect that abuse of resident #001 has occurred, immediately reports the suspicions and the information upon which it was based to the Director, to be implemented voluntarily.***

---

**WN #3: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff fully participated in the implementation of the infection prevention and control program in relation to performing hand hygiene for residents.

Residents on two home areas were not assisted with hand hygiene before snack and lunch. The ADOC said hand hygiene for residents should be completed before and after meals and snacks.

Not assisting residents with hand hygiene placed staff, essential visitors and residents at increased risk for disease transmission.

Sources: Observations, Just Clean Your Hands Long Term Care Home Implementation Guide, interview with ADOC [s. 229. (4)]

***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 staff assist residents with hand hygiene prior to and following meals and snacks, to be implemented voluntarily.***

---

**Issued on this 14th day of April, 2021**

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

**Original report signed by the inspector.**