



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

**Health System Accountability and Performance Division
Performance Improvement and Compliance Branch**

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**Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité**

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 7, 2014	2014_256517_0033	L-000584-14	Critical Incident System

Licensee/Titulaire de permis

S & R NURSING HOMES LTD.
265 NORTH FRONT STREET, SUITE 200, SARNIA, ON, N7T-7X1

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

HERON TERRACE LONG TERM CARE COMMUNITY
11550 McNorton Street, WINDSOR, ON, N8P-1T9

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

PATRICIA VENTURA (517)

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 25, 2014

During the course of the inspection, the inspector(s) spoke with the Manager of Resident Care, two Registered Practical Nurses and two Personal Support Workers.

During the course of the inspection, the inspector(s) reviewed two resident health records and the home's policies, procedures and training records for abuse and neglect.

The following Inspection Protocols were used during this inspection:



Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 failed to ensure that a written policy that promoted zero tolerance of abuse and neglect of residents was complied with as evidenced by:

One Registered Practical Nurse discovered one resident was a recipient of sexual abuse by another resident. The Nurse failed to report the incident of alleged sexual abuse to the Registered Nurse, the Manager of Resident Care or to the Administrator as per the home's Abuse and Neglect policy.

The home's Resident Abuse & Neglect policy # ADMIN 08-05 stated:

"Team members shall notify the Administrator and/or MRC/RN/RPN immediately upon observation or receiving knowledge of a suspected/reported incident of resident abuse".

The Registered Practical Nurse confirmed the incident of alleged sexual abuse was not reported to the Registered Nurse, the Manager of Resident Care or to the Administrator as per the home's Abuse and Neglect policy.

The Registered Practical Nurse further verified being aware that all incidents of alleged abuse needed to be reported to the Registered Nurse, the Manager of Resident Care or the Administrator immediately as per the Abuse and Neglect policy.

The Manager of Resident Care verified that the Abuse and Neglect policy was to be followed at all times and the expectation was that the Registered Practical Nurse notify the Registered Nurse, Manager of Resident Care and or Administrator immediately upon observation or receiving knowledge of an incident of alleged sexual abuse. [s. 20. (1)]



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Issued on this 7th day of August, 2014

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