Ontario

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 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
Jul 11, 2019	2019_509613_0021	012183-19	Critical Incident System

Licensee/Titulaire de permis

Lady Dunn Health Centre
17 Government Road Box 179 Wawa ON P0S 1K0

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

Lady Dunn Health Centre (Wawa)
17 Government Road P.O. Box 179 Wawa ON P0S 1K0

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

LISA MOORE (613), JENNIFER LAURICELLA (542)

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): July 9, 2019.

The following critical incident was inspected during this inspection:

One Critical Incident report that was submitted to the Director regarding allegations of resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Director of Care, Registered Practical Nurses (RPNs) and residents.

The Inspector(s) also conducted a tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, and the zero tolerance of abuse and neglect program.

The following Inspection Protocols were used during this inspection:
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 their written policy to promote zero tolerance of abuse and neglect of residents was complied with related to an incident of alleged abuse involving resident #001.

Inspectors #613 and #542 reviewed a Critical Incident (CI) report that was submitted to the Director, related to an allegation of abuse involving resident #001. The CI report indicated that on a specific date, resident #002 had entered resident #001's room and was attempting to get into resident #001's bed and was holding onto resident #001. Resident #001 informed RPN #100 that the resident #002 had punched them and they were experiencing discomfort. The CI report identified that management was not informed of the alleged abuse until six days after the alleged incident had occurred, where it was noted that resident #001 had bruising to a specific body part.

A review of the home's policy titled, "Zero Tolerance of Abuse and Neglect" last revised on June 27, 2017, identified that all staff, volunteers, contractors and affiliated personnel were required to fulfill their legal obligation to immediately and directly report any witnessed incident or alleged incident of abuse or neglect to the Ministry of Health and Long-Term Care (MOHLTC). Staff was to report the witnessed or alleged incident to a supervisor/manager, Chief Executive Officer (CEO) or Board Chair immediately.

During an interview with the Director of Care, they confirmed that RPN #100 had not reported the alleged incident of abuse immediately to management, as per the home's policy. [s. 20. (1)]

Issued on this 12th day of July, 2019

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

Original report signed by the inspector.