Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection 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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 6, 2016	2016_294623_0018	012717-16	Critical Incident System

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

MAPLEWOOD
12 MAPLEWOOD AVENUE BOX 249 BRIGHTON ON K0K 1H0

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

SARAH GILLIS (623)

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 28 - 30, 2016

The following logs were inspected:
012717-16, related to allegation of resident to resident abuse
028263-15 and 018590-16 related to allegation of staff to resident abuse

During the course of the inspection, the inspector(s) spoke with Residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Director of Care (DOC), Administrator, Office manager,.
The following records were reviewed: policies related to Abuse and Responsive Behaviours; Annual Program Evaluations and education; the licensee`s investigation notes; consult notes; and clinical records.

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.
- **3 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	Legendé 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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

Related to log#028263-15

Review of the homes internal investigation for a staff to resident allegation of abuse/neglect which occurred on a specific date and was reported on a specific date. The licensee completed their internal investigation of the alleged staff to resident abuse towards residents #004 and #005 six days following the initial report. The results of the internal investigation indicate that the allegation of abuse/neglect by PSW#100 towards residents #004 and #005 could not be substantiated. Review of the CIR indicates that an amendment was not completed by the licensee after the initial report on a specific date.

During an interview the Administrator confirmed that there were no amendments made to the CIR after the initial report to indicate the outcome of the licensee's internal investigation, the Administrator was unable to confirm that the Director was notified of the outcome of the internal investigation. Therefore the licensee failed to report to the Director the outcome of the alleged abuse investigation.

Therefore the licensee failed to report to the Director s. 23 (1) a) the results of the investigation and b) every action taken under the clause. [s. 23. (2)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

Related to log#028263-15

Review of the homes internal investigation for a staff to resident alleged abuse/neglect that occurred on a specific date and was reported via a Critical Incident (CIR) to the Director on a specific date. The CIR revealed that the Substitute Decision Maker (SDM) for residents #004 and #005 were initially notified on a specific date to inform them that there was an allegation of abuse towards their loved one. Further review of the clinical records for resident's #004 and #005 as well as the licensee's internal investigation fails provide evidence that the SDM's for residents #004 and #005 were notified of the results of the alleged abuse investigation immediately upon completion.

Administrator confirms that the Director of Care (DOC)#102 completed the homes internal investigation for the CIR. Administrator indicates that they are unable to confirm if the SDM for resident's #004 and #005 were updated as to the outcome of the homes investigation. Administrator confirms that there is no documentation to support that this was completed.

Therefore the licensee failed to ensure that the resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion. [s. 97. (2)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident:
(ii) names of any staff members or other persons who were present at or discovered the incident

Related to Log#028263-15

Review of the homes internal investigation for a specific CIR reveals that the licensee failed to identify PSW#100 as a staff who was present and/or discovered the unusual occurrence. PSW#100 is identified through out the internal investigation file as the accused in the allegation of verbal and physical abuse towards residents #004 and #005.

During an interview the Administrator confirmed that PSW#100 is the accused in this allegation of abuse Critical Incident and should have been identified in the report. [s. 104. (1) 2.]

Issued on this 6th day of July, 2016

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

Original report signed by the inspector.