Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District
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Original Public Report

Report Issue Date: February 6, 2024
Inspection Number: 2024-1286-0001
Inspection Type: Complaint Critical Incident
Licensee: Land O'Lakes Community Services
Long Term Care Home and City: Pine Meadow Nursing Home, Northbrook

Lead Inspector Cathi Kerr (641)	Inspector Digital Signature Cathi Kerr Digitally signed by Cathi Kerr Date: 2024.02.06 15:52:34 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 30, 31, 2024 and February 1, 2, 2024

The following intake(s) were inspected:

- Intake: #00103527 - Critical Incident Report - Alleged staff to resident abuse.
- Intake: #00105703 -Complaint with concerns regarding resident rights and care concerns.

The following Inspection Protocols were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Resident Charges and Trust Accounts

INSPECTION RESULTS

WRITTEN NOTIFICATION: Licensee must investigate.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)
Licensee must investigate, respond and act
s. 27 (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,

The licensee failed to ensure that the allegation of physical abuse of a resident was immediately investigated.

Rationale and Summary

The Inspector reviewed a critical incident which indicated that a PSW allegedly hit a resident. The Inspector reviewed the licensee's investigation documentation related to this incident that indicated their investigation commenced seven days after the incident occurred, when the Administrator first interviewed the PSW.

The Acting Director of Care (ADOC) stated to the Inspector that they had not immediately investigated the allegation of abuse because they hadn't been aware of the severity of the incident.

Failure to immediately investigate the alleged incident of physical abuse posed potential risk to the residents in the home.

Sources: Critical Ipncident report , licensee's investigation documentation, interviews with the ADOC. [641]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The licensee failed to ensure that a person who had reasonable grounds to suspect abuse of a resident immediately report the suspicion to the Director.

Rationale and Summary

The Inspector reviewed a critical incident which indicated that a PSW was observed striking a resident. The critical incident was submitted to the Director twelve days after the incident occurred.

During an interview with the Inspector, a PSW stated they didn't report the incident to the charge nurse until a day or two later but were aware that they were required to report it immediately. During a separate interview, another PSW indicated to the Inspector that they had been informed of the incident immediately after it happened but didn't inform the charge nurse of the incident until the next day.

During an interview with the Inspector, the Acting Director of Care (ADOC) indicated they had not immediately submitted a critical incident to the Director for the suspicion of alleged abuse of a resident because they hadn't been initially aware of the severity of the incident.

Failure to immediately report the alleged incident of physical abuse to a resident posed a potential risk to the residents in the home.

Sources: Critical incident report, licensee's investigation documentation, interviews with PSWs and the ADOC. [641]