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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Nov 22, 2013	2013_230134_0016	O-000746-13	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

LONGFIELDS MANOR
330 BEATRICE DRIVE, NEPEAN, ON, K2J-5A5

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

COLETTE ASSELIN (134)

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): November 20, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurse (RN), Registered Nursing Assistant (RPN), several Personal Support Workers(PSW) and Resident #1.

During the course of the inspection, the inspector(s) reviewed Resident #1's health records, the Licensee's Policy "Resident Non-Abuse" #LP-C-20-ON and reviewed the critical incident report.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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. 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 comply with the LTCHA, 2007 S.O. 2007, Chapter 8 s. 20 (1), in that the Licensee's Policy on "Non-Resident Abuse" # LP-C-20, was not complied with.

On a specified date in August 2013, there was a witnessed incident of non-consensual touching between Resident #1 and a female co-resident. This incident of sexual abuse was not reported immediately to the Director. The incident was reported 2 days later via the Critical Incident System (CIS).

The Licensee's Policy - "Resident Non-Abuse" # LP-C-20-ON" was reviewed. There is an entry under section "Mandatory Reporting" on page 4, that specifies the following: "Any staff member or person, who becomes aware of and/or has reasonable grounds to suspect abuse or neglect of a resident must immediately report the suspicion and information on which it is based to the Executive Director or delegate". There is a second entry which specifies that under the LTCHA, Section 24 (1) it requires a person to make an immediate report to the Director of the Ministry of Long term Care, where there is reasonable suspicion that abuse of a resident by anyone occurred.

Furthermore, there is an entry under bullet #5 of the "Interventions and Consequences for those Who Abuse Resident" section on page 7, which specifies the following: "The appropriate police force will be notified of any alleged, suspected or witnessed abuse or neglect of a resident that may constitute a criminal offence".

The DOC and Administrator were interviewed November 20, 2013 and indicated the police force had not been called on a specified date in August 2013, when Resident #1 was sexually abusive toward a female co-resident. As such, section 98 of the O. Reg. 79/10 and the Licensee's policy # LP-C-20-ON, were not complied with. [s. 20. (1)]

Issued on this 22nd day of November, 2013

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