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 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
Nov 27, 2018	2018_729615_0043	000169-18, 024885-18, 027108-18	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 8) GP Inc. as general partner of CVH (No. 8) LP
766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Queensway Long Term Care Home
100 Queen Street East P.O. Box 369 HENSALL ON N0M 1X0

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

HELENE DESABRAIS (615)

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 19, 2018.

The following Critical Incident (CI) reports were completed within this inspection:

CI #0933-000001-18/Log #000169-18 related to prevention of abuse and neglect;
CI #0933-000007-18/Log #024885-18 related to prevention of abuse and neglect;
CI #0933-000009-18/Log #027108-18 related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Assistant Director of Care (ADOC), a Registered Practical Nurse (RPN) and a Personal Support Worker (PSW).

During the course of the inspection, the inspector observed staff and resident interactions, reviewed residents' clinical records, investigative notes and relevant policies and procedures.

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

On a specific date the home submitted Critical Incident (CI) #0933-000007-18/Log #024885-18 to the Ministry of Health and Long Term Care (MOHLTC) related to staff to resident alleged verbal abuse.

The Ontario Regulation 79/10 defines "verbal abuse" as (a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident, or (b) any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences. ("mauvais traitement d'ordre verbal") O. Reg. 79/10, s. 2 (1).

A review of the home's policy RC-02-01-02 "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" last updated April 2017, stated in part "Anyone who witnesses or suspects abuse or neglect of a resident by another resident, staff or other person must report the incident. The report may be made to the home and/or external

authorities. At minimum, any individual who witnesses or suspect abuse or neglect of a resident must notify management immediately. The LTCHA provides that any person who has reasonable grounds to suspect that any of the following has occurred, or may occur, must immediately report the suspicion and the information upon which it is based to the Director of the Ministry of Health and Long Term Care".

A review of the home's documentations and CI, on a specific date, a Personal Support Worker (PSW) witnessed another PSW being verbally abusive towards a resident. This incident was reported to the Nurse in Charge of the home at the time who emailed the Executive Director (ED) and the Director of Care (DOC) to inform them of the incident. A day after, the DOC was aware of the alleged abuse of the resident and initiated an investigation where it was confirmed that the resident had been verbally abused by a PSW. The DOC, then, reported the alleged abuse to the MOHLTC four days later.

During interviews, Assistant Director of Care (ADOC) #100, Registered Practical Nurse (RPN) #101 and PSW #102 all stated that any suspicion or allegation of abuse should be reported immediately to the Director.

During an interview, ADOC #100 stated that they had talked with the DOC on the telephone and that the DOC agreed that they reported the alleged abuse late, and that the home's expectation would be that any suspicion or allegation of abuse should be reported immediately to the Director. [s. 24. (1)]

Issued on this 3rd day of December, 2018

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

Original report signed by the inspector.