Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 19, 26, 30, Nov 1, 2, 2012	2012_128138_0041	Critical Incident

Licensee/Titulaire de permis

BRUYERE CONTINUING CARE INC.
43 BRUYERE STREET, OTTAWA, ON, K1N-5C8

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

RESIDENCE SAINT- LOUIS
879 CHEMIN PARC HIAWATHA, OTTAWA, ON, K1C-2Z6

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

PAULA MACDONALD (138)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with Director, Long Term Care, both Directors of Care (DOC), registered nurses (RN), registered practical nurses (RPN), personal care attendants (PCA), and a family member.
The inspection occurred on site on October 26, 2012.

During the course of the inspection, the inspector(s) obtained and reviewed the following: Critical Incident reports, resident health records, the home's abuse policy, documents related to the home's internal investigations, and documents relating to annual training.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

s. 23. (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,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007 s. 23. (1) (a) in that the licensee of a long term care home did not ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated.

A morning in June 2012, a resident reported to a RPN that a PCA physically abused him/her in that the PCA hit him/her with a bottle. The RN confirmed to LTCH Inspector that the RPN reported to him/her that a resident accused a PCA of hitting him/her with a bottle. The PCA also stated to LTCH inspector that s/he reported the incident and allegations from the resident that same day to the RN. The RN further stated s/he was preoccupied with other work at that time and did not report the incident to the DOC until two days later when the resident refused to be cared for by the PCA. The investigation into the allegations of physical abuse began as soon as the DOC became aware of the incident, two days after the alleged incident occurred. During the two days from the time the incident was first reported until the DOC became aware, the PCA who was accused of hitting the resident with a bottle was continued to be assigned to care for the resident. The PCA was suspended once the investigation began and until the investigation was completed.

WN #2: 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 subsections:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007 s. 24, (1) in that a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred did not immediately report the suspicion and the information upon which it was based to the Director.
A morning of June 2012, a resident reported to a RPN that a PCA physically abused him/her in that a PCA hit him/her with a bottle. The RN confirmed to LTCH Inspector that the RPN reported to him/her that a resident accused a PCA of hitting him/her with a bottle. The PCA also stated that s/he reported that same day to RN the allegations of the resident. The RN further stated s/he was preoccupied with other work at that time and did not report the incident to the DOC until two days later when the resident refused to be cared for by the PCA. An email from the RN to the DOC confirmed that the RN forgot to advise the DOC of the incident. The DOC informed the Director of the incident once she became aware, two days after the incident occurred.

Issued on this 2nd day of November, 2012

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