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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
April 27, 28, May 5, 10, 11, 2011	2011_164_2894_28Apr094117	Critical Incident – T-842-11

Licensee/Titulaire
Revera Long Term Care Inc., 55 Standosh Court, 8th Floor, Mississuaga, ON L5R 4B2

Long-Term Care Home/Foyer de soins de longue durée
Sherwood Court Long Term Care Centre, 300 Ravineview Drive, Maple, ON L6A 3P8

Name of Inspector(s)/Nom de l'inspecteur(s)
Gloria Still, Inspector #164; Susan Lui, Inspector 174

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a follow up to a critical incident related to alleged staff to resident abuse.

During the course of the inspection, the inspectors spoke with: Executive Director, Director of Care, Registered Staff, Personal Support Workers, Residents.

During the course of the inspection, the inspectors: Reviewed the following documents: critical incident report; 24 hour nursing report; resident's health record; Resident Non-Abuse Policy; Serious Adverse Event Management Policy; Home's internal investigation; Human Resource Records; new employee orientation package; in-service education training. Observed staff/resident interactions.

The following Inspection Protocols were used in part or in whole during this inspection: Prevention of Abuse, Neglect and Retaliation

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
3 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.
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.)	Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with the Long Term Care Homes Act, 2007, S. O. 2007, s. 23. (1) (a) (i) (ii) (iii)

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;

Findings:
A reported incident of alleged staff to resident abuse was not immediately investigated by the home.

VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, every alleged, suspected or witnessed incident of abuse that the licensee knows of, or that is reported to the licensee, is immediately investigated. The plan is to be implemented voluntarily.

WN #2: The Licensee has failed to comply with the Long Term Care Homes Act, 2007, S. O. 2007, s. 24 (1) 2.
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.**

Findings:
- The licensee upon receiving a report of alleged abuse did not immediately notify the Director.

VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that 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 information upon which it is based to the Director. The plan is to be implemented voluntarily.

WN #3: The Licensee has failed to comply with the Long Term Care Homes Act, 2007, O. Reg. 79/10, s. 97. (1) (b)
Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Findings:
- The resident's POA was not notified of the alleged abuse within 12 hours.

VPC - pursuant to the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. The plan is to be implemented voluntarily.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné		Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.
Title:	Date:	Date of Report: (if different from date(s) of inspection). May 25, 2011