Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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
May 22, 2020	2020_771609_0005	001171-20	Critical Incident System

Licensee/Titulaire de permis

Smooth Rock Falls Hospital
107 Kelly Road P.O. Box 219 SMOOTH ROCK FALLS ON P0L 2B0

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

Smooth Rock Falls Hospital
107 Kelly Road P.O. Box 219 SMOOTH ROCK FALLS ON P0L 2B0

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

CHAD CAMPS (609)

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): March 9, 11, 13, 2020.

The following intake was inspected upon during this Critical Incident System (CIS) Inspection:
-One intake related to alleged physical abuse of a resident.

During the course of the inspection, the inspector(s) spoke with the Long-Term Care Coordinator (LTCC), Registered Practical Nurses (RPNs) and residents.

The Inspector(s) also conducted a daily tour of the resident care areas; observed staff-to-resident and resident-to-resident interactions; reviewed internal investigations; relevant health care records as well as the home's 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.
- **2 WN(s)**
- **1 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 was protected from abuse by anyone.

Ontario Regulation (O. Reg.) 79/10 defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

A Critical Incident (CI) report was submitted by the home to the Director on a particular day which described how resident #001 complained of pain. By the next day staff noted the resident had impaired skin integrity.

Inspector #609 reviewed resident #001's health care records and found in progress notes on a particular day, that the resident began to complain of pain. Physician #105 assessed the resident and noted they had impaired skin integrity and diagnostic testing was ordered.

A review of resident #001's testing results found that the resident had sustained an injury.

A review of the home's internal investigation found an interview with Registered Practical Nurse (RPN) #106 that resident #001 had indicated that Personal Support Worker (PSW) #103 was the cause of their pain.

A review of the home's policy titled "Zero Tolerance of Abuse and Neglect Policy" last reviewed January 2020 stated that all residents would be free from any form of abuse or neglect at all times and in all circumstances.

During an interview with RPN #102, they described hearing an altercation between resident #001 and PSW #103 around the time the resident began complaining of pain. The resident was heard yelling and refused to let the PSW touch them again.

A review of correspondence between the home and PSW #103 outlined grounds that the PSW was involved in resident #001's injury. [s. 19. (1)]

Additional Required Actions:

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 resident #001 as well as all other residents are protected from abuse by anyone, to be implemented voluntarily.

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:

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 that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

A CI report was submitted by the home to the Director on a particular day which outlined how two days previously impaired skin integrity was noted by Physician #105. See Written Notification (WN) #1 for further details.

A review of the home's policy titled "Zero Tolerance of Abuse and Neglect Policy" last reviewed January 2020 stated that after hours, the staff member who discovered or suspected abuse would immediately call the after hours.

During an interview with the LTCC, they described how Hospital Manager #107 was their delegate on a particular day when the Hospital Manager was made aware of the suspicion of abuse of resident #001. The Hospital Manager then informed the LTCC via telephone of the suspicion the following day. The LTCC verified that Hospital Manager #107 did not call the afterhours, nor did the LTCC on the next day. They further verified that they did not notify the Director until two days after the suspicion of abuse was identified, when the LTCC completed a CI report. [s. 24. (1)]

Issued on this 29th day of May, 2020

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

Original report signed by the inspector.