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**


**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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 23, 2018 | 2018_520622_0026 | 008831-18, 009887-18, 010553-18 | Critical Incident System |

### Licensee/Titulaire de permis

Diversicare Canada Management Services Co., Inc.
2121 Argentia Road Suite 301 MISSISSAUGA ON L5N 2X4

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

Perth Community Care Centre
101 Christie Lake Road, R. R. #4 PERTH ON K7H 3C6

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

HEATH HEFFERNAN (622)

### 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): September 14, 17, 18, 19, 20, 21, 25, 2018.**

**Log #010553-18 related to alleged staff to resident improper/incompetent treatment. Log #008831-18 and Log #009887-18 related to alleged staff to resident abuse.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Nurses, Personal Support Workers and the residents.**

**During the course of the inspection, the inspector reviewed the applicable critical incident reports and investigation documentation, health records, the licensee's policy and procedure related to Zero Tolerance for Resident Abuse and Neglect and made observations of staff to resident interactions.**

**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<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 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.

O. Reg. 79/10, s. 2 (1). States the definition for physical abuse is as follows:

(a) the use of physical force by anyone other than a resident that causes physical injury or pain,
(b) administering or withholding a drug for an inappropriate purpose, or
(c) the use of physical force by a resident that causes physical injury to another resident.

A review of the Critical Incident System report (CIS) indicated that Director of Care (DOC) #102 received an email on a specified date time one day after an incident alleging abuse of residents #002 and #003 by Personal Support Worker (PSW) #106.

A review of the email from Registered Nurse (RN) #107 to DOC #102 related to the alleged abuse of residents #002 and #003 by PSW #106 was dated one day earlier than the date the email was received by DOC #102.

A review of the progress notes documented by RN #107 for resident #002 dated on a specified date indicated the resident had been crying due to what they felt was roughness and pain caused during their care by PSW #106. There was no injury to resident #002.

A review of the progress notes documented by RN #107 for resident #003 dated on a specified date indicated that resident #003 reported to RN #107 that they felt PSW #106 was rough during care. There was no injury to resident #003.

During an interview with inspector #622, RN # 107 stated on a specified date, both residents #002 and #003 had claimed that PSW #106 was rough during care. RN #107 stated they could not recall but thought that they had placed a telephone call to DOC #102 to report the incident on the specified date and received direction to send DOC #102 an email. RN #107 said that the alleged staff to resident abuse related to residents #002 and #003 by PSW #106 should have been reported to the Ministry of Health and Long-Term Care immediately on the date when the concerns were noted.

During an interview with inspector #622, the Administrator said that RN #107 had not reported the alleged staff to resident abuse of residents #002 and #003 by PSW #106 immediately. RN #107 should have called the Ministry of Health and Long-Term Care by telephone immediately on the specified date when the concerns were reported to them and not sent by email to DOC #102 to follow up the next morning. [s. 24. (1)]

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**Issued on this 24th day of October, 2018**

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

**Original report signed by the inspector.**