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
Mar 26, 2019	2019_674610_0015	004101-19	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Elmwood Place
46 Elmwood Place West LONDON ON N6J 1J2

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

NATALIE MORONEY (610)

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 14, 15, 18, 2019

This Critical Incident Inspection (CIS) #2662-000005-19, Log #004101-19 was conducted related to allegations of physical abuse from resident to resident.

The following Follow-up to CO#001 inspection #2019_674610_0006 / 028689-18 was completed concurrently regarding s. 19. (1) Duty to Protect related to Skin and Wound Care, compliance date of Mar 08, 2019.
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During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Director of Care, Clinical Consultant Manager, Registered Nurse(s), Registered Practical Nurse(s), Personal Support Worker(s), Behavioural Support Manager, Wound Care Nurse, and resident(s).

Inspector reviewed relevant documentation as well as resident health care records, conducted interviews, and completed observations.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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 had failed to ensure that any person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was 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 risk of harm.

The home submitted a Critical Incident System (CI) report to the Ministry of Health and Long-Term Care (MOHLTC) regarding allegations of abuse from one identified resident to another identified resident.

A review of record documentation showed that the allegations of abuse had occurred on a specific day an assessment was completed on the identified resident who was struck and showed an injury related to the earlier incident. There was no documented evidence that Assistant Director of Care (ADOC) had reported the abuse to the MOHLTC on the specific day of the incident.

A review of the licensee's "Mandatory Reporting of Resident Abuse and Neglect" policy stated in part that, any person who has reasonable grounds to suspect that any of the following occurred or may occur that they must immediately report the suspicion to the Director of the Ministry of Health: related to abuse of a resident by anyone or neglect of a resident that resulted in harm or a risk of harm.

The ADOC had reviewed the CI report and stated that at the time of the incident they felt there was no harm to the identified resident who was struck by the other identified resident.

The licensee had failed to ensure that any person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director for the identified resident related to allegations of abuse by a another resident that resulted in harm or risk of harm.

Issued on this 27th day of March, 2019

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

Original report signed by the inspector.