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 28, 2019	2019_786744_0006	033056-18, 002499-19, 005160-19	Critical Incident System

Licensee/Titulaire de permis

The West Nipissing General Hospital
725 chemin Coursol Road STURGEON FALLS ON P2B 2Y6

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

The West Nipissing General Hospital
725 chemin Coursol Road STURGEON FALLS ON P2B 2Y6

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

STEVEN NACCARATO (744)

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 11-14, 2019

A Follow-up inspection #2019_786744_0005 was completed concurrently with this Critical Incident System (CIS) Inspection.

The following intakes were inspected during the CIS inspection:

-One intake related to a critical incident the home submitted to the Director regarding a resident eloping from the home;
-One intake related to a critical incident the home submitted to the Director regarding a staff to resident abuse; and
-One intake related to a critical incident the home submitted to the Director regarding a written complaint.

During the course of the inspection, the inspector(s) spoke with the Administrator, Chief Nursing Officer, Long-term Care Unit Manager, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

The Inspector also observed resident care areas, the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, internal investigation documents and policies and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse was complied with.

Inspector #744 reviewed a Critical Incident System (CIS) report that was submitted to the Director, which outlined allegations of abuse by RPN #101 to resident #001, witnessed by PSW #103 three days prior.

The home's policy, "Zero Tolerance of Abuse and Neglect" policy (#100.122, revised September 21, 2018), was reviewed. The policy indicated that, all staff, visitors, students, contractors, and family members have the duty to immediately report any alleged, suspected or witnessed abuse and/or neglect of a resident/patient. The policy indicated the requirement of immediate notification to the unit Manager/delegate or Manager on call (MOC) of the abuse or neglect is alleged, suspected or witnessed and that resulted in harm or risk of harm to the resident.

PSW #103 was interviewed and stated that they reported the incident days later, after being questioned by the Clinical Nurse Manager. They stated that abuse should be reported immediately to the manager on call but that they did not want to get anyone in trouble.

The Long-term Care Unit Manager was interviewed and said that they would be the designated person that would have received the report of abuse. The Inspector reviewed the critical incident report with the Long-term Care Unit Manager. Upon review, they confirmed that the resident abuse should have been reported immediately as per the home's policy.

The licensee failed to ensure that the home's Zero Tolerance of Abuse and Neglect policy regarding immediate reporting was complied with. [s. 20. (1)]

Issued on this 29th day of March, 2019

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

Original report signed by the inspector.