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
Jun 10, 2020	2020_771609_0009	005632-20	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

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): June 3, 4, 5, 8, 2020, as an off-site inspection.

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

During the course of the inspection, the inspector(s) spoke with Chief Executive Officer (CEO), Chief Nursing Officer (CNO), Clinical Managers (CMs), Personal Support Workers (PSWs) and Dietary staff.

The Inspector(s) also 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.
- **1 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. 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 written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A Critical Incident (CI) report was submitted by the home to the Director which described how weeks previously, staff member #105 witnessed two other staff members exit resident #001's room laughing because the resident had engaged in a specific activity.

Inspector #609 reviewed the home's policy titled "Zero Tolerance of Abuse and Neglect" last revised January 28, 2019, which indicated that all staff had a duty to immediately report any alleged, suspected or witnessed abuse and/or neglect of a resident to the unit manager/delegate.

During an interview with staff member #105, they described how on a particular day they saw two other staff members leaving resident #001's room. The two staff members were laughing and making disrespectful gestures.

Staff member #105 indicated that the incident made them unsettled but did not report the allegations to the home. They indicated that they reported the incident to their manager weeks later, after a co-worker advised them to.

During an interview with Clinical Manager (CM) #102, a review of the CI report was conducted. They verified that staff member #105 did not comply with the home's abuse policy when they did not immediately report the allegations of abuse to the Registered Practical Nurse (RPN) who would in turn have immediately reported the allegations to the manager on call.

A review of a letter issued to staff member #105 outlined how staff member #105 violated the home's "Zero Tolerance of Abuse and Neglect" policy when they did not immediately report the allegations of abuse of resident #001 on the day the incident occurred. [s. 20. (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 the home's written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

Issued on this 11th day of June, 2020

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

Original report signed by the inspector.