Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: March 21, 2024	
Inspection Number: 2024-1479-0001	
Inspection Type: Critical Incident	
Licensee: The West Nipissing General Hospital	
Long Term Care Home and City: The West Nipissing General Hospital, Sturgeon Falls	
Lead Inspector Barbara Humenjuk (000741)	**Inspector Digital Signature** Barbara Humenjuk Digitally signed by Barbara Humenjuk Date: 2024.04.08 08:46:01 -04'00'
Additional Inspector(s) Training Specialist Keara Cronin was also present during this inspection.	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 4 to 7, 2024

The following intake(s) were inspected:

- One Intake regarding abuse of a resident by staff

The following **Inspection Protocols** were used during this inspection:

Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (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.

The Licensee has failed to protect a resident from abuse.

Rationale and Summary

A PSW argued with a resident, grabbed them by the arm pulling them out of their chair and pushed them from behind.

The PSW admitted that their actions were inappropriate and that they should have left the resident as they were.

As a result of the incident, the resident's response and mood were negatively affected placing them at moderate risk.

Sources: record review: investigation file; observation: video footage; interviews with the resident and registered staff. [000741]

WRITTEN NOTIFICATION: Late reporting

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director
s. 28 (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:
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.

The Licensee failed to ensure that an incident of alleged abuse of a resident was immediately reported to the Director.

Rationale and Summary

The allegation of abuse was reported to the Director one day after the incident occurred.

The home confirmed that the report was late being reported.

The late reporting had minimal risk and impact to the resident.

Sources: record review: INFO Line and CI Report; observations: Photo of Mandatory Reporting Procedures; interviews: with registered staff. [000741]