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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 6, 2015	2015_362138_0005	O-001041-14	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

WINBOURNE PARK
1020 Westney Road North AJAX ON L1T 4K6

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

PAULA MACDONALD (138)

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): January 29, 2015

The inspector also conducted a job shadowing activity with an employee of the Ministry of Health and Long Term Care during this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), and Residents. Other activities conducted on the inspection included a review of Critical Incident Report, review of a resident's health care record, review of the home's internal investigation documents, review of employee training documents, tour of the home to observe for mandatory postings, observation of staff to resident interactions, and a review of the home's policy on abuse.

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 WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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 O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee failed to make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident.

In accordance with this section and sections 23.(2) and 23.(1)(a)(i) of the Act, the licensee is required to report to the Director (Ministry of Health and Long Term Care) the results of every investigation undertaken related to every alleged, suspected or witness incident of abuse of a resident by anyone within 10 days of becoming aware of the alleged, suspected or witnessed abuse.

The home received a concern from Resident #001's family member on a day in September 2014, that Resident #001 had made a statement that s/he had been treated roughly by staff the previous evening while care was being provided. The home submitted a preliminary report to the Director that same day, outlining the information that was available at the time this preliminary report was made. The inspector held a discussion with the Executive Director regarding the incident and the Executive Director stated that the home conducted an internal investigation immediately, that the results of the investigation were inconclusive of abuse, and that the investigation was completed either one or two days after the incident was reported. The inspector also spoke with the PSW involved in the incident, Staff #101, who stated to the inspector that she had been suspended with paid for one shift pending investigation and that she had returned to work a day later, when the home informed her that the internal investigation was complete and there was no conclusion that abuse occurred. This demonstrates that the home concluded its internal investigation one to two days after becoming aware of the incident.

It was noted by the inspector, however, that the preliminary report sent to the Director had not been updated with the results of the home's internal investigation within the 10 days of becoming aware of the incident. It was noted on the report that the home was requested by an inspector eight days after the preliminary report was submitted to update the report with the outcomes of the investigation. An updated report was not submitted by the home until twenty three days after the preliminary report was made. [s. 104. (2)]

Issued on this 6th day of February, 2015

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

Original report signed by the inspector.