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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 31, 2017	2017_548592_0016	015366-17	Critical Incident System

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

WOODLAND VILLA
30 Milles Roches Road R. R. #1 Long Sault ON K0C 1P0

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

MELANIE SARRAZIN (592)

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): July 18, 19 and 20, 2017

One Critical Incident was inspected during the inspection. Log #015366-17 related to allegations of suspected staff to resident sexual abuse.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), RN Clinical Care/ADOC, Registered Nursing Staff, Personal Support Workers (PSW) and residents.

The inspector observed the provision of care and services to residents, observed staff to resident interactions, residents' environment, reviewed resident health care records and reviewed Licensee policies on internal investigation and prevention of abuse and neglect.

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	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 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 failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

According to O.Reg.79/10, s.2.(1), sexual abuse is defined as any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a person the use of force by a licensee or staff member.

On a specific date, a Critical Incident report was submitted to the Director describing an incident of alleged sexual abuse which had occurred two days before, from PSW #101 to resident #001, whereby resident #001 was standing holding onto the bar in the bathroom while the continent care product was changed by PSW #101 and the resident #001 felt the genitals of PSW #101 touching his/her back and PSW #101 was at the same time breathing heavily.

On July 18, 2017, during an interview with Inspector #592, RN #100 indicated that resident #001 reported to her an incident of alleged sexual abuse which had occurred the day before. Rn #100 further indicated that she was not present on the day of the incident but that the resident indicated that he/she thought about it all day as it altered his/her sleep the night after the incident and he/she was fearful and he/she felt violated. RN #100 indicated that each registered staff member is responsible to immediately inform the MOHLTC after becoming aware of an alleged incident of abuse. She further indicated that she was the registered staff responsible on that day and that she was unsure what to do as it was serious sexual accusation, therefore left a note to the DOC who was not on site with the details of the incident.

On July 18, 2017, in an interview with the DOC, she indicated to Inspector #592 that she was not made aware of the incident until the next day by RN #100. The DOC further indicated that RN #100 should of contact her or the Administrator immediately upon becoming aware of the incident as she was the person in charge of the home.

The report of alleged sexual abuse between staff #101 and resident #001 was not reported immediately to the Director. [s. 24. (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 that the person who had reasonable grounds to suspect that neglect of a resident by staff that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director,, to be implemented voluntarily.

Issued on this 31st day of July, 2017

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

Original report signed by the inspector.