Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Sep 23, 2019	2019_543561_0015	011525-19	Critical Incident System

Licensee/Titulaire de permis

Halton Healthcare LTC Inc.
327 Reynolds Street OAKVILLE ON L6J 3L7

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

Wyndham Manor Long Term Care Centre
291 Reynolds Street OAKVILLE ON L6J 3L5

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

DARIA TRZOS (561)

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 19 and 20, 2019.

The Critical Incident System (CIS) report number 2910-000012-19, log #011525-19 was completed during this inspection related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), physician, Social Worker, registered staff including Registered Nurses (Rns) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), detectives from Halton Regional Police Service, and residents.

During the course of the inspection, the inspector toured the home, observed provision of care, reviewed clinical records, investigation notes, video footage, any relevant documentation related to the incident, police report, polices and procedures, training records, and annual evaluation of the abuse program.

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001 was protected from abuse by anyone.

The Long-Term Care Homes Act, 2007, O. Reg 79/10, includes the definitions of abuse.

The home reported an alleged staff to resident abuse to the Ministry of Long Term Care (MOLTC) on an identified date, followed by a Critical Incident System (CIS) report. CIS report indicated that resident #001 reported that they were subjected to an incident involving a PSW working in the home on an identified date.

The review of clinical records and the investigation notes identified that PSW #103 was inappropriate towards resident #001 and they were able to point who the PSW was. The home took action and reported this to the MOLTC and the police. The home also had footage of events from the identified date; however, that footage did not capture the exact actions of inappropriate behvaiour of the PSW.

Resident #001 was interviewed by the LTCH Inspector #561; however, refused to respond to questions asked related to the identified incident. The resident did state that they felt safe and comfortable in the home.

The police report was obtained from the detective and stated that the resident was questioned and was able to describe the incident. The detective assigned to the case was also interviewed by the Inspector.

The DOC was interviewed and confirmed the events that were documented in the investigation notes. They stated that even though there were no witnesses, they believed that resident #001 was abused by PSW #103.

The licensee failed to ensure that resident #001 was protected from abuse by the staff in the home. [s. 19. (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 residents are protected from abuse by anyone, to be implemented voluntarily.

Issued on this 23rd day of September, 2019

[redacted]

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

Original report signed by the inspector.