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**

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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 13, 2019 | 2019_729615_0051 | 016637-19 | Critical Incident System |

## Licensee/Titulaire de permis

County of Oxford
21 Reeve Street WOODSTOCK ON N4S 7Y3

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

Woodingford Lodge - Tillsonburg
52 Venison Street West TILLSONBURG ON N4G 1V1

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

HELENE DESABRAIS (615)

## 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): September 3, 2019.**

**The following Critical Incident (CI) was inspected during this inspection:**

**CI #M615-000007-19/Log #016637-19 related to responsive behaviours and prevention of abuse, neglect and retaliation.**

**During the course of the inspection, the inspector(s) spoke with the Manager and two Personal Support Workers.**

**The inspector also reviewed clinical records and plan of care for the identified residents, policies and procedures and other relevant document.**

**The following Inspection Protocols were used during this inspection:**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**

**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<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident that resulted in harm or a risk of harm occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

On a specific date, Critical Incident (CI) #M615-000007-19/Log #016637-19 was submitted to the Ministry of Health and Long Term Care (MOHLTC) related to resident to resident alleged physical abuse that resulted in an injury of a resident that occurred a few days before.

Review of CI #M615-000007-19 stated, in part, that a resident was found on the floor in an area of the home and they stated that a resident had been physically aggressive towards them and the same resident had two previous incidents of physical aggression towards residents on two previous dates.

A review of the home's policy #T 6.045 "Resident Abuse - Zero Tolerance for Abuse and Neglect" last revised on May 14, 2019, stated, in part "Physical abuse means the use of physical force by anyone other than a resident that causes physical injury or pain. Examples of physical abuse include, but limited to: hitting, pushing, biting, slapping, scratching, shaking, pinching, using force, kicking or handling the resident in a rough manner." and, "Everyone has the duty to immediately report any of the issues listed below to the Director at the Ministry of Health and Long Term Care (MOHLTC), if you know or have reasonable grounds to suspect that the resident has been harmed or might be harmed. Reporting is a requirement for the licensee, people who work at WDFL, and those who provide professional services in the areas of health, social work or social services to residents and/or licensee."

A review of the resident's progress notes for the two previous dates indicated that the resident had been physically aggressive towards other residents causing them harm.

During interviews, two Personal Support Workers both stated that the incidents were suspected abuse and that they should have been reported immediately to the Director.

During an interview, the Manager stated that the Registered Nurse working during these incidents were the staff in charge of the home at the time and should have reported the incidents 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 to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident that resulted in harm or a risk of harm occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.***

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**Issued on this 13th day of September, 2019**

[redacted]

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

**Original report signed by the inspector.**