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 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
Apr 29, 2019	2019_789435_0007	007092-18, 014229-18, 015502-18, 017388-18, 020288-18, 028835-18, 030056-18, 030629-18, 031889-18, 033383-18, 033630-18	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of Niagara
1815 Sir Isaac Brock Way THOROLD ON L2V 4T7

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

The Woodlands of Sunset
920 Pelham Street WELLAND ON L3C 1Y5

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

AMBERLY COWPERTHWAITE (435), CHRISTINA LEGOUFFE (730), INA REYNOLDS (524)

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): April 23 - 26, 2019

The following intakes were completed during this Critical Incident Inspection:
Log # 007092-18,
Log # 014229-18,
Log # 015502-18,
Log # 017388-18,
Log # 020288-18,
Log # 028835-18,
Log # 030056-18,
Log # 030629-18,
Log # 031889-18,
Log # 033383-18, and;
Log # 033630-18

During the course of the inspection, the inspector(s) spoke with the Director of Resident Care, the Associate Director of Resident Care, Registered Practical Nurses, Registered Nurses, Personal Support Workers, Physiotherapist, and the Clinical Documentation and Informatics Coordinator. Inspectors also completed record review, clinical record review, and observations during this inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
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 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse of residents was complied with.

Review of the home's policy titled "Abuse and Neglect – Zero Tolerance" Index No: RR00 -001 with reviewed date March 12, 2019, stated that "Staff must immediately report all alleged, suspected or witnessed incidents of abuse and neglect of residents."

During review of a Critical Incident System (CIS) reported to the Ministry of Health and Long-Term Care Infoline on an identified date and time, documented an incident of staff to resident alleged physical abuse on an identified date.

Review of the home's investigation notes documented that a Personal Support Worker (PSW) witnessed their co-worker slap an identified resident while providing care on the identified date. The PSW said in a written statement that they were shocked that this had happened. The PSW did not inform the registered staff on duty when the incident occurred but informed the Registered Nurse (RN) the following day on the evening shift.

In an interview, the identified RN confirmed that the identified PSW came to see them the following evening shift after the incident, and told them what they had observed on the previous evening shift. The RN acknowledged that the suspected physical abuse should have been reported immediately as per the home's policy. The RN initiated an investigation immediately upon hearing of the incident and appropriate actions were taken by the home in response to the incident.

In an interview with the Director of Resident Care (DRC), they acknowledged that the identified PSW had not followed the home's policy by not reporting immediately. The DRC said that the expectation was that staff report immediately to the registered staff if they suspect or witness any abuse. [s. 20. (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 staff follow the home's written policy to promote zero tolerance of abuse of residents, to be implemented voluntarily.

Issued on this 29th day of April, 2019

[redacted]

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

Original report signed by the inspector.