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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 27, 2017	2017_589641_0010	026719-16, 032523-16, 033420-16	Critical Incident System

Licensee/Titulaire de permis

AON INC.
33 HARBOUR SQUARE SUITE 825 TORONTO ON M5J 2G2

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

MOIRA PLACE LONG-TERM CARE HOME
415 RIVER STREET WEST TWEED ON K0K 3J0

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

CATHI KERR (641)

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): March 21, 20, 22 and 23, 2017

This inspection was conducted in reference to three critical incidents, Log #033420 -16, and Log #026719-16 related to missing residents from the home for less that three hours, and Log #032523-16 related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator (Admin), the Director of Care (DOC), Physician, Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents, and Resident's Family. During the course of the inspection, the Inspector observed resident care, reviewed resident heath care records and relevant policies and procedures related to Zero Tolerance of Abuse and Neglect and Guidelines for Critical Incident Reporting.

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.
- **2 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 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 had failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Critical incident #2977-000031-16 was submitted to the Ministry of Health and Long Term Care related to an alleged staff to resident abuse that occurred on a specified date.

The Inspector interviewed Physician #102 on March 21, 2017, who indicated that on a specified date, she overheard PSW #101 speak inappropriately and use offensive language, while doing personal care on resident #002. The Physician indicated that she reported what she saw and heard to RPN #100.

During an interview with PSW #101 on March 21, 2017, she acknowledged that she had spoken inappropriately in front of the resident. She indicated that she was speaking her thoughts out loud, had not intended for the resident to hear her and regretted saying them.

During an interview with the Inspector on March 21, 2017, RPN #100 indicated that Physician #102 had reported to her what she had overheard in resident #002's room by PSW #101. The RPN indicated that she forgot to tell her supervisor about this incident. She indicated that she was aware that when there was a suspicion of abuse of a resident, she must communicate that to her supervisor immediately.

Inspector #641 interviewed the Director of Care (DOC) on March 22, 2017. She indicated that the expectation of the home was that when the RPN was informed of the alleged abuse of resident #002 by PSW #101, she should have immediately reported this to her supervisor who was the RN in charge that day. The RN would then notify the DOC and or the Administrator right away. She was aware that the RPN did not report this incident to the RN as their policy indicated.

The licensee's Abuse and Neglect, Zero Tolerance Policy #HR-F-11 stated "All employees are expected to be vigilant and immediately report suspected cases of resident abuse or neglect to their supervisor."

RPN #100 failed to comply with the licensee's policy to promote zero tolerance of abuse and neglect of a resident by not immediately reporting the alleged abuse of resident #002 by PSW #101 to a supervisor. Log #032523-16 [s. 20. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that the Director was immediately informed when any missing resident returns to the home with an injury, regardless of the length of time the resident was missing.

Critical incident #2977-000033-16 was submitted to the Ministry of Health and Long Term Care on a specified date, related to resident #003 being away from the home two days earlier for a period of time and sustaining several injuries.

During an interview with the Inspector on March 22, 2017, PSW #104 indicated that she had assisted resident #003 back to the home on a specified date. She indicated that the resident had several injuries.

Upon return to the home, the resident was assessed by RPN #107. During an interview with the Inspector on March 23, 2017, RPN #107 indicated that she had reported the incident to her supervisor, the RN in charge, sometime after she had attended to the resident.

During an interview with the Inspector on March 22, 2017, the Director of Care (DOC) #103 indicated that if a resident was wandering off the property this was considered to be an elopement. She indicated that the expectation of the home was that when a resident was missing off the property, this would be reported to either herself or the Administrator immediately, regardless of whether the resident was injured or not. She indicated that she was aware that this incident with resident #003 should have been reported to the Director immediately.

The licensee's Guidelines for Critical Incident Reporting Policy #GA-E-45B indicated that "Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing" required a report submitted to the Director - "Immediately initiate and submit the on-line CIS form identifying this as a Critical Incident". The policy further indicated that the reporting time frame was "Immediately: full report within 10 days of becoming aware of the incident."

The licensee failed to immediately report to the Director that resident #003 had eloped from the home and had sustained several injuries. Log #033420-16 [s. 107. (1) 4.]

Issued on this 28th day of March, 2017

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

Original report signed by the inspector.