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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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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 10, 2017	2017_509617_0012	009926-17	Critical Incident System

Licensee/Titulaire de permis

AUTUMNWOOD MATURE LIFESTYLE COMMUNITIES INC.
130 ELM STREET SUDBURY ON P3C 1T6

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

CEDARWOOD LODGE
860 GREAT NORTHERN ROAD SAULT STE. MARIE ON P6A 5K7

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

SHEILA CLARK (617)

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 6 - 9, 2017

This Critical Incident Inspection is related to a critical incident report #7093-000010-17, submitted by the home, regarding resident to resident abuse.

Observations were made of the home areas and the provision of care and services to residents during the inspection. The home's policies and procedures, resident health records and staff scheduling, training and personnel records were reviewed.

During the course of the inspection, the inspector(s) spoke with the acting Administrator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members, and residents.

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 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 :

The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

A Critical Incident System (CIS) report was submitted by the home to the Director regarding an incident of alleged resident to resident abuse. The incident was reported to the after-hours Long Term Care Home Emergency pager in May 2017. The CIS report indicated that resident #001 disclosed to resident #003, that resident #002 displayed a socially inappropriate action towards resident #001.

Inspector #617 interviewed the Administrator, who confirmed that resident #002's inappropriate action displayed towards resident #001 was an incident of alleged abuse that required to be immediately reported to the Director.

In the home's investigation, the Inspector found a written account of resident #003 reporting the conversation they had with resident #001 disclosing the inappropriate action, to the life enrichment coordinator #101 the day before it was reported to the Director. The home was made aware of the incident on a specific day in May 2017, and reported the incident to the Director one day later.

A review of the home's policy titled, "Zero Tolerance of Abuse and Neglect - #NP-070", last revised February 2017, indicated that all staff, volunteers, contractors and affiliated personnel were required to
-immediately report to the appropriate supervisor in the home on duty and/or the Administrator at the time of a witnessed or alleged incident of abuse, and
-legally obligated to immediately and directly report any witnessed incident or alleged incident of abuse to the Ministry of Health Long Term Care (Director).

On June 7, 2017, in interviews with PSWs #103 and #104, they both stated to the Inspector respectively that if they witnessed or were informed of suspected resident abuse they were required to report the incident immediately using the home’s reporting procedures.

In an interview with the Administrator, they confirmed to the Inspector that the home became aware of the incident in May 2017, when resident #003 reported to the life enrichment coordinator #101 what resident #001 had disclosed to them. The Administrator further explained that the home's policy and procedure for reporting had required the life enrichment coordinator #101 to report this incident immediately to the Director when they became aware of the alleged abuse. [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 has reasonable grounds to suspect that abuse of a resident by anyone that occurs resulting in harm or risk of harm, immediately reports the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

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Issued on this 11th day of July, 2017

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

Original report signed by the inspector.