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

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Inspection de sions de longue durée

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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
Apr 18, 2016	2016_365194_0004	004177-16	Complaint

Licensee/Titulaire de permis

BELCREST NURSING HOMES LIMITED
250 Bridge Street West BELLEVILLE ON K8P 5N3

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

Belmont Long Term Care Facility
250 Bridge Street West BELLEVILLE ON K8P 5N3

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

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 02, 03, 04, 07 and 08, 2016

Critical incident log #015569-15 and log #018318-15 related to resident to resident sexual abuse, Complaint log #004177-16 resident to resident sexual abuse, Critical incident log #001536-16, #022225-15, #028936-15 staff to resident abuse and log #026449-15 improper care of a resident.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care(DOC), Registered Nurse(RN), Registered Practical Nurse(RPN)and Personal Support Worker(PSW).

The inspector also reviewed clinical health records, the licensee's internal abuse investigation notes, staff educational records, responsive behaviour program, abuse and pain policies. Also observed staff to resident provision of care.

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

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **3 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #006 and #001 as specified in the plan.

Log #028936-15 related to resident #001 and #006;

On an identified date, PSW #116 was overheard by DOC speaking in a harsh voice to resident #006 and resident #001 in the lounge while assisting with the lunch meal.

Critical Incident report and interview with DOC indicated that PSW #116 was responsible for providing assistance to resident #006 and resident #001 during the lunch meal in the lounge. DOC indicated that both residents sit in the lounge during meals related to responsive behaviours that are disruptive. DOC indicated that she overheard PSW #116 say in a harsh voice to resident #006 "that's enough, just eat" and to resident #001 "sit down".

The plan of care for resident #006 identifies that the resident has cognitive impairments. The plan of care for resident #006 identifies that the resident has repetitive behaviours and staff need to provide reassurance, redirection and talk with resident in a low pitch, calm voice to decrease anxiety.

The plan of care for resident #001 identifies that the resident has cognitive impairments, wanders and is restless. MDS indicates that resident #001 will get up and leave before the staff start to serve the meal and will continually get up to leave during the meal. Staff have to remind and assist resident #001 to sit so the resident will eat the meal. The plan

of care also directs that staff provide reassurance and patience when communicating to resident #001.

On an identified date, PSW #116 did not provide care to resident #006 and #001 as set out in the plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that when resident #002 was reassessed, the plan of care which had not been effective, was changed to provide different approaches in the revision of the plan of care.

Log #004177-16 related to resident #001 and #002;

On an identified date, a staff witnessed resident #002 being sexually inappropriate towards resident #001. One month later, a non staff member witnessed resident #002 being sexually inappropriate towards resident #001.

The plan of care for resident #002 after the first incident, was changed to include increased monitoring. Resident #002 was relocated within the home after the second incident. The plan of care for resident #002 was reviewed by the inspector three days after the second incident and it did not provide any different approaches for the resident's inappropriate sexual responsive behaviour. [s. 6. (11) (b)]

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 by ensuring that the plan of care for residents #001 and #006 are provided as specified related to responsive behaviours at meals. The plan of care for resident #002 will be revised to ensure that different approaches are considered related to the sexually inappropriate responsive beahviour, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #008's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Log #026449-15 related to resident #008;

Resident # 008 is totally dependent on staff for all ADL's. Resident #008's clinical health records indicate an increase pain over a two month period.

MARS(Medication administration records) for an identified month indicate that the resident was receiving an analgesic three times a day and when necessary a (PRN) order. Over the identified month, the PRN analgesic was administered 10 times.

The progress notes and the Medication Administration Records (MARS) for the following month indicated that the resident's analgesic was increased twice. The first time, the PRN analgesic was increased from twice a day to three times a day and the second time the routine analgesic was increased to a narcotic.

Resident #008 was transferred to the hospital in the second identified month for further assessment as requested by the physician and diagnosed with an injury, and returned to the home with an narcotic analgesic order, every two hours PRN for pain.

Review of the Minimum Data Set (MDS) for resident #008 during the period of four months, indicate that the resident was having pain.

The pain policy for the home was reviewed and provides a clinically appropriate assessment instrument specifically designed for pain assessments to be used by staff.

During an interview RPN #118 indicated that there is a pain assessment tool, in the Point

Click Care(PCC)and the pain assessments were not being completed for residents on a quarterly basis. RPN #118 has indicated that she would use breakthrough analgesics and hot packs if a resident presented with pain. RPN #118 indicated that if a resident presented with a new pain, she would notify the doctor and have him assess and order medications as required, she further indicated that monitoring of new pain medication was completed at the home by documenting in PCC and communicating any problems to the physician.

Resident #008 had an increase in pain, pre and post injury as well as an increase in pain medication. There is no evidence that resident #008 was assessed using the clinically appropriate pain assessment instrument over a two month period. [s. 52. (2)]

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 ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that there are written approaches to care developed to meet the needs of the residents with responsive behaviours, written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviour.

Review of the home's behavioural program was conducted by inspector and directs;

Psycho geriatric program - Policy # NS.1-0250 (currently under revision) June 2003, as well as "Management of Aggressive Resident Behaviour" Policy # RSCM-E-115 July 15, 2010.

The policy for "Management of Aggressive Resident Behaviour" identifies strategies, and

interventions to manage aggression, anger and agitation behaviour. There is no other policy/documentation to address any other behaviours.

-There is no written approaches to care including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours whether cognitive, emotional, social, environmental or other.
-There are no strategies, including techniques and intervention, to prevent, minimize or respond to responsive behaviours other than physical.
-there are no resident monitoring and internal reporting protocols . (example 1:1 monitoring)

During interview DOC indicated being aware that the home's behaviour program only addressed physical behaviours and was currently reviewing the program to include the other forms of responsive behaviours. [s. 53. (1) 1.]

2. The licensee has failed to ensure that strategies have been developed and implemented for resident #002 to respond to the sexually inappropriate responsive behaviours.

Log #004177-16 related to resident #001 and #002;

On an identified date, a staff witnessed resident #002 being sexually inappropriate towards resident #001. One month later, a non staff member witnessed resident #002 being sexually inappropriate towards resident #001.

Resident #002 is ambulatory in the home.

Resident #001 is cognitively impaired, ambulates in a wheelchair and wanders on the unit.

Review of plan of care for resident #002 does not identify enhanced monitoring after the first incident. The plan of care does not identify that (Depression Observation Scale) DOS is being completed or that the resident was relocated within the home.

Strategies to identify any other resident's at potential risk were not identified after the first incident or second incident. Strategies to minimize the interaction with resident #001 was not developed or implemented once the enhanced monitoring was stopped, after the the

first incident. [s. 53. (4) (b)]

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 by ensuring that a responsive behaviour program is developed to meet the needs of residents with responsive behaviours which include;
-Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other
-Written strategies, including techniques and interventions, to prevent, minimize or respond to the resident #002's sexually inappropriate responsive behaviours, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).

8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion,

discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).
20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 s. 3(1)1 by not ensuring that the following rights of residents were fully respected and promoted.
1. Every resident has the right to be treated with courtesy and respect in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Log #001536-16 related to resident #005

Resident #005 is cognitively well and able to give direction related to care needs.

During an interview with the inspector, resident #005 is immediately able to recall the incident and states "this is the second incident with this particular nurse". Resident #005 indicates that "both times I told the nurse not to provide my medication" while in the dining room. Resident #005 continues to explain that the nurse would not listen and gave the medication anyway.

ADOC #113 indicates that it is not the general practice of nursing staff to administer specific treatments in the dining room. ADOC #113 indicates that resident #005 is able to direct the care being provided by staff.

Resident #005's right to be treated with courtesy and respect was not fully respected and promoted when a medication treatment was administered against the resident's wishes in the dining room by RPN #115. [s. 3. (1)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated:
(i) Abuse of a resident by anyone

Log #022225-15 related to resident #007;

On an identified date, RPN #118 received a telephone call from the POA of resident #007. The POA expressed concerns related to resident #007 being in bed early the previous evening and that the resident stated being afraid of getting into trouble with staff for requesting assistance with care.

RPN #118 has indicated to inspector that the comments made by the POA were an allegation of abuse by staff to a resident. RPN #118 indicated completing a statement and e-mailing it to the DOC and the ADOC that morning. RPN #118 explains this is the usual method of communicating to management staff in the home.

During an interview the DOC indicated being made aware of the allegations of staff to resident abuse three days later, where an investigation into the allegations was immediately initiated. The results of the investigation indicated that no staff to resident abuse had occurred involving resident #007. [s. 23. (1) (a)]

WN #6: 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. 1.The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Log #026449-15 related to resident #008;

On an identified date, RN #124 was informed by the family of resident #008 that , PSW #122 had not respected the resident, attempted to reposition without first informing the resident of the actions, which resulted in pain to the resident. Resident #008 had just returned from the hospital with an injury.

An e-mail was forwarded on an identified date to the DOC by RN #124, informing her of the voiced concerns from the family.

During an interview the DOC indicated speaking to RN #124 on an identified date, to discuss the family concerns related to administration of medication, but had not been informed of the allegations of staff to resident physical abuse. The DOC explained to the inspector that she became aware of the allegations of abuse by the family during a meeting the following day and an investigation into the situation was immediately commenced.

The Director was notified of the allegation of staff to resident abuse, twenty four hours after the incident was reported.

Log #022225-15 related to resident #007;

On an identified date, RPN #118 received a telephone call from the POA of resident #007. The POA expressed concerns related to resident #007 being in bed early the previous evening and that the resident stated being afraid of getting into trouble with staff for requesting assistance with care.

RPN #118 indicated to inspector that the comments made by the POA were an allegation of abuse by staff to a resident. RPN #118 indicates that she wrote up the statement and emailed it to the DOC and the ADOC that morning. RPN #118 explains this is the usual method of communicating to management staff in the home.

During an interview the DOC indicated being made aware of the allegations of staff to resident abuse three days later, where she reported to the Director and initiated an investigation into the allegations. The results of the investigation indicated that no staff to resident abuse had occurred involving resident #007. [s. 24. (1)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff receive training in the home policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities.

During interview with inspector #194 the DOC indicated that RPN #115 started to work at the home, as an agency staff. Review of the educational records indicate that RPN #115 was not provided education on abuse and neglect prior to performing his/her responsibilities. [s. 76. (2) 3.]

2. The licensee has failed to ensure that staff receive training in the area of mandatory reporting under section 24 of the Act of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to a resident, prior to performing their responsibilities.

During telephone interview Administrator has indicated RPN #115 an agency staff, was not provided with training in mandatory reporting, improper or incompetent treatment of care, unlawful conduct, abuse or neglect resulting in harm or potential harm to a resident, prior to performing responsibilities. [s. 76. (2) 4.]

Issued on this 19th day of April, 2016

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

Original report signed by the inspector.