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
Aug 16, 2019	2019_786744_0025	012520-19	Complaint

Licensee/Titulaire de permis

Board of Management for the District of Parry Sound West
21 Belvedere Avenue PARRY SOUND ON P2A 2A2

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

Belvedere Heights
21 Belvedere Avenue PARRY SOUND ON P2A 2A2

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

STEVEN NACCARATO (744)

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): August 6-8, 2019.

One intake was completed during this Complaint inspection:
-A complaint submitted to the Director related to an alleged incident of staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and their family members.

The inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, home investigation notes, as well as licensee policies and procedures.

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

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	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. 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 had occurred, or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

A complaint was submitted to the Director, which alleged staff to resident abuse. The complainant identified that the incident was immediately reported to the home and the home had investigated the incident shortly after but was never reported.

On December 18, 2019, the Director notified the Long-term Care Homes, via a memo, of important reference materials on the mandatory reporting requirement, specifically, "Question and Answer" document related to the "Essential Reporting Requirements for Long-Term Care Homes Workshop". The "Question and Answer" document included a question related to "reasonable grounds" on page 14 of 18, and indicated that the Legislation did not define "reasonable" grounds for reporting abuse; however, provided an example, that if the home had an indication that the abuse may have taken place the home was to report the allegations to the Director immediately and investigate.

Inspector #744 reviewed the Ministry of Long-Term Care's online Critical Incident System (CIS) reporting portal and was unable to identify that a CIS report was submitted for this allegation of staff to resident abuse.

In an interview with Inspector #744, the CEO indicated that they were notified of an alleged abuse at a specific time and notified the Director of Care (DOC) 10 minutes later to initiate an internal investigation into their suspicion of abuse. A debrief of the investigation occurred approximately one hour after the CEO was notified, between the CEO and DOC, in which it was decided that the Ministry was not to be notified of the alleged abuse.

Inspector #744 reviewed the home's policy titled "Critical Incident Reporting" effective date November 2012, which indicated that the Chief Executive Officer (CEO) will immediately initiate the online Mandatory Critical Incident System (MCIS) or after hours pager when there is a suspicion of abuse of a resident by anyone.

In a further interview with the CEO, they indicated that the suspicion of abuse should be reported immediately to the after hours Ministry reporting line if they were made aware of allegations of abuse after 1700 hours. The CEO indicated that although they initially had suspicions of resident abuse, they were satisfied that abuse did not occur after the DOC conducted their investigation. The CEO confirmed that the Ministry should have been immediately informed as soon as they were suspicious of the abuse, but they did not do so. [s. 24. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's Substitute Decision Maker (SDM) was notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident.

A complaint was submitted to the Director, which alleged staff to resident abuse. The complainant identified that the incident was immediately reported to the home and the home had investigated the incident shortly after. The complainant further indicated that they were unsure that the SDM was made aware of the incident.

Inspector #744 reviewed resident #001's progress notes, which did not indicate that the SDM was contacted.

In an interview with Inspector #744, the CEO indicated that after receiving a phone call of the alleged abuse, a call was made to the DOC a short time after to investigate the incident. After the investigation was completed, the DOC contacted the CEO back to debrief about the investigation.

Inspector #744 reviewed the home's policy titled "Prevention of Abuse and Neglect ZERO Tolerance" effective date August 2018, which indicated that the CEO must notify the SDM when abuse of that resident has, or is suspected to have occurred: Within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident.

In a further interview with the CEO, they indicated that the SDM should be notified immediately after an abuse allegation. They indicated that some allegations do not warrant a call to the SDM until an investigation was conducted first. The CEO further confirmed that the SDM was never notified of this allegation of abuse. [s. 97. (1) (b)]

Issued on this 16th day of August, 2019

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

Original report signed by the inspector.