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

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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
Jun 7, 2017	2017_418615_0012	004128-17, 004183-17	Critical Incident System

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF LONDON
c/o Dearness Home for Senior Citizens 710 Southdale Road East LONDON ON N6E 1R8

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

DEARNESS HOME FOR SENIOR CITIZENS
710 SOUTHDALE ROAD EAST LONDON ON N6E 1R8

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

HELENE DESABRAIS (615)

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): May 8, 2017.

This complaint, IL-49473-LO/004128-17 and Critical Incident M514-000003-17/004183 -17 inspection were related to Prevention of Abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), two Assistant Directors of Care (ADOCs) and one Registered Practical Nurse (RPN).

During the course of the inspection, the inspector observed resident care provision, reviewed relevant resident clinical records and 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.
- **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. 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 that promotes zero tolerance

of abuse and neglect of residents was complied with.

A review of a resident's progress notes showed documented behaviours demonstrated by the resident and a concern related to alleged abuse.The note specified that the physician and the resident's Power of Attorney were contacted and requested to have the resident sent to the hospital.

A review of the home's policy "Resident Abuse - Staff to Resident" reviewed March 2013, stated that "All Staff: Immediately report (verbally) any suspected or witnessed abuse: to the Administrator, Director of Care, or their designate (e.g. supervisor, department head); The Administrator, Director of Care, or their designate must report the incident, as required by provincial and jurisdictional requirements" to the MOHLTC Director through the Critical Incident Reporting System/ after hours pager".

During an interview, a ADOC, said that the hospital called the home stating that the resident reported that there was "abuse going on". The police were called by the hospital at that time. The ADOC shared that the home initiated an investigation of the alleged abuse as soon as they were aware of it. The ADOC stated that when reviewing the resident's progress notes the alleged abuse was documented.

During an interview, the DOC and two ADOCs, shared that an RPN was working that day and was getting the resident ready for the hospital transfer. They stated that the resident had demonstrated behaviours and told staff about a concern related to alleged abuse. The supervisor, a Registered Nurse, was also present but on the phone at that time and did not hear the resident’s conversation with the RPN. The resident was then transferred to the hospital.

During an interview, the RPN said that on a specific date that staff shared that the resident’s behaviours were escalating and that these behaviours were unusual for the resident. The RPN said that the resident was reporting alleged abuse by staff. The RPN stated “I did not report it to my supervisor because I was so swamped” trying to get the resident ready for the hospital transfer. The RPN said that the abuse was charted after the transfer to the hospital, that a PSW and an RPN student were present and heard the conversation with the resident. The RPN stated that the supervisor, Registered Nurse was on the phone with the POA at that time of the conversation with the resident.

During an interview, a ADOC and the Administrator, shared that the home’s expectation was that the staff would report allegations of abuse immediately to a manager as per the

home's policy.

The licensee failed to ensure that where there is a written policy that promotes zero tolerance of abuse and neglect of residents that it is complied with.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was determined to be isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on October 20, 2015, as a Voluntary Plan of Correction (VPC) in a Complaint Inspection #2015_277538_0033, on November 16, 2015 as a Written Notification (WN) in a Resident Quality Inspection #2015_277538_0033 and, July 12, 2016 as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection # 2016_260521_0028. [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 the written policy that promotes zero tolerance of abuse and neglect of residents is complied with and, to be implemented voluntarily.

Issued on this 8th day of June, 2017

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

Original report signed by the inspector.