Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Mar 6, 2020	2020_785732_0007	024317-19, 000242-20, 001882-20, 002265-20	Critical Incident System

Licensee/Titulaire de permis

Rural Healthcare Innovations Inc.
533 Clarence Street P.O. Box 970 WINCHESTER ON K0C 2K0

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

Dundas Manor Nursing Home
533 Clarence Street P.O. Box 970 WINCHESTER ON K0C 2K0

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

EMILY BROOKS (732), MARK MCGILL (733)

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): January 30 and 31, 2020; February 3 and 4, 2020; and March 2-5, 2020.

The following intakes were completed during this Critical Incident System inspection:

Log #024317-19 (CIR 2674-000028-19) related to falls prevention
Log #000242-20 (CIR 2674-000002-20) and log #002265-20 (CIR 2674-000004-20) related to alleged staff to resident improper/incompetent treatment of a resident
Log #001882-20 (CIR 2674-000003-20) related to personal support services

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RN), a Registered Practical Nurse (RPN), Personal Support Workers (PSW), and residents and their families.

The inspector(s) reviewed resident health care records, relevant investigation records, and relevant policies; as well as observed the provision of care and services to residents, staff to resident interactions, and overall resident observations.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in resident #004's plan of care was provided to the resident as specified in the plan.

A Critical Incident Report (CIR) was submitted to the Director describing the alleged improper/incompetent treatment of resident #004 by PSW #108. Resident #004 told Inspector #732 that while PSW #108 was changing their brief, PSW #108 shoved them on their side in bed, pushed down on their limb that had chronic pain, was rough with care, and was rude. Resident #004 explained that they did not need assistance to move in bed and PSW's are to ask and explain care before performing. Resident #004 told inspector #732 that they tried to direct the care, however, the PSW was rude and physically and emotionally abusive.

Resident #004's plan of care indicated that resident #004 required no assistance for the physical process of bed mobility, and that the resident is independent. The plan of care also indicated to allow resident #004 to direct their care.

In summary, the licensee has failed to ensure that resident #004's care was provided as specified in their plan of care. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004 was protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A Critical Incident Report (CIR) was submitted to the Director describing the alleged improper/incompetent treatment of resident #004 by PSW #108. Resident #004 told Inspector #732 that while PSW #108 was changing their brief, PSW #108 shoved them on their side in bed, pushed down on their limb with pain, was rough with care, and was rude. Resident #004 explained that they do not need assistance to move in bed and PSW's are to ask and explain care before performing. Resident #004 told inspector #732 that they tried to direct the care, however, the PSW was rude and physically and emotionally abusive.

In an interview with DOC #102, they told inspector #732, that after speaking with PSW #108 during their investigation, they believed that there was some intent to not provide proper care to resident #004, and that there was no remorse from PSW #108. DOC #102 told Inspector #732 that they considered that emotional abuse. PSW #108's employment was terminated.

In conclusion, the licensee failed to protect resident #004 from emotional abuse. [s. 19. (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 residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

Issued on this 6th day of March, 2020

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

Original report signed by the inspector.