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 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
Feb 22, 2019	2019_634513_0002	001015-18, 002678-18, 027303-18, 028608-18	Complaint

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

Erin Mills Lodge Nursing Home
2132 Dundas Street West MISSISSAUGA ON L5K 2K7

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

JUDITH HART (513), MATTHEW CHIU (565)

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): January 8, 10, 11, 14, 15, 16, 17, 18, 21, 22, 23, and 24, 2019.

The following complaint intakes were inspected: Log #001015-18, related to neglect, log #002678-18, related to falls, log #027303-18, and log #028608-18, related to financial abuse.

A Written Notification of non-compliance related to LTCH Act, 2007, s. 24 (1), identified in a concurrent critical incident inspection #2019_634513_0001, (log #015183-17) will be issued in this report.

During the course of the inspection, the inspector(s) spoke with the Senior Vice President (East Region), General Manager (GM), Director of Nursing Care (DNC), Assistant Director of Care (ADOC), Registered Practical Nurses (RPN), Physiotherapist (PT), Personal Support Workers (PSW), Dietary Aide (DA), Maintenance Staff, Residents, Family Members, and Substitute Decision Maker (SDM).

During the course of the inspection, the inspector(s) observed staff and resident interactions, the provision of care, reviewed health records and any relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **1 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 the person who had reasonable grounds to suspect abuse of a resident by anyone, which resulted in harm or risk of harm to a resident, immediately reported the suspicion and the information upon which it was based to the Director.

A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) dated in 2018, concerning alleged financial abuse of resident #016. The home submitted an associated critical incident system (CIS) report.

The record review included a letter of complaint on a specified date in 2018, stamped as received on another specified date in 2018, regarding resident #016, which identified concerns related to financial abuse.

A review of the CIS report for resident #016 regarding this previously noted complaint was dated as submitted to the MOHLTC on on a later specified date in 2018.

During the inspection, resident #016 was deceased and no longer in the home.

An interview with the Director of Nursing Care (DNC) indicated that they spoke with the complainant on a specified date in 2018, regarding resident #016 and suggested they contact corporate office to answer questions related to specific staff identified by the

complainant. They indicated that several names were identified in resident #016's will and they wanted confirmation of names of the home's staff.

An interview with the Senior Vice President, Eastern Region, acknowledged receipt of the above identified letter at their corporate offices, on the above specified dates in 2018, and spoke with the complainant regarding their concerns.

An interview with the DNC identified they initially spoke with the complainant on a specified date in 2018, and approximately three weeks later notified the Director. The DNC confirmed the complaint was not immediately reported to the Director.

2. A CIS report for resident #018 was submitted to the MOHLTC on a specified date in 2017, for an incident of alleged staff to resident abuse that was identified on a specified date in 2017.

A review of the home's investigation notes on a specified date in 2017, indicated that during a family meeting with the resident's substitute decision maker (SDM) and the DNC on a specified date in 2017, resident #018 had reported to the SDM allegations of staff to resident physical and verbal abuse.

A review of the above mentioned CIS report was submitted to the Director on a specified date in 2017.

An interview with the DNC indicated the CIS report should be submitted to the MOHLTC right away and confirmed that in this instance the allegation of staff to resident abuse was not reported to the Director immediately. [s. 24. (1)]

Issued on this 26th day of February, 2019

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

Original report signed by the inspector.