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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 1, 2017	2016_260521_0049	033131-16	Critical Incident System

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF GREY
595 9th Avenue East OWEN SOUND ON N4K 3E3

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

LEE MANOR HOME
875 SIXTH STREET EAST OWEN SOUND ON N4K 5W5

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

REBECCA DEWITTE (521)

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): November 24, 2016,

This Critical Incident #M549-000013-16 pertained to an alleged abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Nutritional Manager, a Personal Support Worker, the Social Worker, a resident, a family member and a visitor.

The inspector(s) also observed staff to resident interactions, completed a resident record review and a policy review.

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)**
- **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. 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 had occurred of a resident or may occur of a resident, immediately reported the suspicion and the information upon which it was based to the Director.

A review of a Critical Incident Systems Report documented that an alleged incident of abuse occurred.

The review of the Critical Incident Systems Report submitted to the Ministry of Health and Long-Term Care indicated that the alleged incident was reported late to the Ministry of Health and Long-Term Care.

A review of the home's policy Prevention of Abuse & Neglect of a Resident included that "All employees, volunteers, agency staff, private duty caregivers, contracted service providers, residents, and families are required to immediately report any suspected or known incident of abuse or neglect to the Director of MOHLTC and the Executive Director/Administrator or designate in charge of the home".

An interview with Administrator verified the Critical Incident Systems Report was late in being reported to the Director because the home had followed the Licensee Reporting of Abuse Decision Tree provided to the home by the Ontario Compliance Branch, Accountability and Performance Division.

The Administrator also confirmed it was the home's expectation that the person who had reasonable grounds to suspect abuse of a resident immediately report the suspicion and the information upon which it was based to the Director.

The scope of the incident was isolated, the severity of the incident had potential for harm and the compliance history was a two with one or more unrelated non compliance. [s. 24. (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 person, who had reasonable grounds to suspect abuse had occurred of a resident or may occur of a resident, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

An allegation of abuse occurred.

An Inspection Team Lead (ITL) from the London Service Area Office placed a phone call to the home and spoke with the Administrator, Director of Care and Assistant Director of Care to obtain more information related to a Critical Incident Systems Report. During the conversation, the Administrator stated that they had not notified the police. Later that same afternoon, another ITL placed a phone call to the home to inquire if they had notified the police and was told that the home would contact the police in the morning. Later in the evening a Service Area Office Manager placed a call to the home and requested that they notify the police that evening.

The licensee failed to ensure that the appropriate police force was immediately notified of alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence.

The scope of the incident was isolated, the severity of the incident was a minimum risk and the compliance history was a two with one or more unrelated non compliance. [s. 98.]

Issued on this 14th day of February, 2017

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

Original report signed by the inspector.