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**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
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**Public Copy/Copie du public**

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Mar 12, 2014 | 2014_288549_0014 | O-000189-14 | Critical Incident System |

**Licensee/Titulaire de permis**

UNITED COUNTIES OF LEEDS AND GRENVILLE
746 County Road 42, P.O Box 100, ATHENS, ON, K0E-1B0

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

MAPLE VIEW LODGE
746 COUNTY ROAD, 42 EAST, P.O. BOX 100, ATHENS, ON, K0E-1B0

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

RENA BOWEN (549)

**Inspection Summary/Résumé de l'inspection**

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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 6, 7 and 10, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Employee Services Representative (HR), several Registered Nurses (RN), several Registered Practical Nurses (RPN) , a Personal Support Worker (PSW) and a Housekeeper (HSK).

During the course of the inspection, the inspector(s) observed resident care being provided, reviewed Resident #1's health care record, the home's Abuse Investigation documentation related to Critical Incident # M554-000003-14, the home's mandatory Reporting and Whistle-Blowing Protection Policy # MVL-ADM-2011-01 (issued August 2,2011) Resident Abuse policy # MVL-RESPROC1 (revision date, August 28, 2012) Resident Abuse policy # MVL-RESPOL1 (revision Date, August 28, 2012), "Every Resident- Bill of Rights for people who live in Ontario long term care homes" documentation dated December 2011, Prevention of Abuse and Neglect education session outline, staff abuse training records, PSW # S100 summary of disciplinary action.

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

Findings of Non-Compliance were found during this inspection.

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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 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 comply O.Reg. 79/10 , s. 98 in that home did not ensure that the appropriate police force was notified immediately of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

On a specific date in February 2014, RPN # S102 reported to the ADOC that PSW # S100 was rude and verbally abusive towards Resident #1.

It was also reported by PSW #S101 that PSW S#100 refused to toilet Resident #1 when Resident #1 asked to be toileted.

The home notified the Ministry of Health and Long Term Care after hours services immediately of the alleged Abuse/Neglect and completed a Critical Incident Report.

During an interview with the ADOC he indicated that the home did not know they where required to call the police.

The police were not informed immediately of the alleged abuse and neglect. [s. 98.]

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Issued on this 12th day of March, 2014

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

RENA BOLDEN RN #549.