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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 9, 2015	2015_290551_0017	O-001708-15, O-001709-15, O-001722-15, O-001896-15	Critical Incident System

Licensee/Titulaire de permis

NORTH RENFREW LONG-TERM CARE SERVICES INC.
47 Ridge Rd DEEP RIVER ON K0J 1P0

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

NORTH RENFREW LONG-TERM CARE SERVICES INC.
47 RIDGE ROAD P.O. BOX 1988 DEEP RIVER ON K0J 1P0

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

MEGAN MACPHAIL (551)

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): June 29 and 30, 2015.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), a Food Service Worker, the Manager of Resident Services and the Administrator.

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)**
- **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	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 suspected verbal abuse of Resident #3 and Resident #2 was immediately reported to the Director.

On a specified day in February 2015, a suspected incident of verbal abuse between a staff member and Resident #2 and Resident #3 was observed by a Food Service Worker, Staff Member #104.

The day following the incident, Staff Member #104 reported her suspicion of staff to resident abuse involving Resident #2 and Resident #3 to the Administrator.

The Administrator began an investigation immediately but did not notify the Director of the suspected staff to resident verbal abuse until two days later. [s. 24. (1)]

2. The licensee has failed to ensure that the suspected verbal abuse of Resident #5 and Resident #4 was immediately reported to the Director.

According to the Critical Incident Report (CIR) and the home's internal investigation notes, on a specified day in February 2015, suspected incidents of verbal abuse between a staff member and Resident #5 and Resident #4 was observed by PSW, Staff Member #103.

The day following the incident, Staff Member #103 reported her suspicion of staff to resident abuse involving Resident #5 and Resident #4 to the Manager of Resident Services.

The Manager of Resident Services began an investigation immediately but did not notify the Director of the suspected staff to resident verbal abuse until two days later.

On a specified day in March 2015 the home amended the CIR to indicate that they were now aware of the requirement to immediately report any suspected abuse to the Director. [s. 24. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident #3, Resident #2, Resident #5 and Resident #4's substitute decision makers were notified within 12 hours upon becoming aware of any suspected abuse.

On a specified day in February 2015, Food Service Worker, Staff Member #104 reported her suspicion of staff to resident abuse involving Resident #3 and Resident #2 to the Administrator.

On a specified day in February 2015, PSW, Staff Member #103 reported her suspicion of staff to resident abuse, involving Resident #5 and Resident #4 to the Manager of Resident Services.

According to information contained in the Critical Incident Report (CIR) and the home's internal investigation notes, the home did not contact Resident #3, Resident #2, Resident #5 and Resident #4's substitute decision makers to notify them of the allegation of abuse until twenty three days later.

On a specified day in March 2015 the home amended the CIR to indicate that they were now aware of the requirement to notify the substitute decision maker, and any other person specified by the resident, within 12 hours of becoming aware of any suspected abuse. [s. 97. (1) (b)]

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Issued on this 9th day of September, 2015

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

Original report signed by the inspector.