Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Inspection Report under the LTC Homes Act, 2007 ☒ Public Copy ☐ Licensee Copy	**Rapport d'inspection prevue de le Loi de 2007 les foyers de soins de longue durée** ☐ Copie du Titulaire ☒ Copie de la Publique	
Date(s) of inspection/Date de l'inspection July 27, 2010	**Inspection No/ d'inspection** 2010_141_2915_26Jul162349	**Type of Inspection/Genre d'insptection** Critical Incident Log# H-00072
Licensee/Titulaire Oakwood Retirement Communities Inc. 325 Max Becker Drive, Suite 201, Kitchener, Ontario, N2E 4H5		
Long-Term Care Home/Foyer de soins de longue durée Riverside Glen Long Term Care Facility 60 Woodlawn Road East, Guelph, Ontario, N1H 8M8		
Name of Inspector(s)/Nom de l'inspecteur(s) Sharlee McNally LTC Inspector - Nursing #141		

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection related to an allegation of staff to resident abuse received at the Hamilton Service Area office on July 7, 2010

The inspection was conducted by 1 Inspector.

The inspection occurred on July 27, 2010.

During the course of the inspection, the inspector(s) spoke with:
The Administrator and Director of Care for the facility, the resident involved in the critical incident, the Resident Assessment Inventory (RAI) coordinator (backup), and staff on the Puslinch home area.

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

Six Findings of Non-Compliance were found during this inspection. The following action was taken:
6 WN
2 VPC

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé.

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.)

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Plan of correction/Plan de redressement
DR – Director Referral/Régisseur envoye
CO – Compliance Order/Ordres de conformité
WAO – Work and Acitvity Order/Ordres: travaux et activitiés

WN#1: The Licensee has failed to comply with: LTCHA 2007, S.O 2007, c. 8, s.23(1)(b)

Every licensee of a long-term care home shall ensure that, (b) appropriate action is taken in response to every such incident

Findings:

1. An identified resident reported an allegation of physical and emotional abuse towards her by a staff person. The staff person threatened to withdraw care, and struck at the resident with her hand. The home did investigate the allegation of physical abuse but did not identify or investigate the allegation of emotional abuse related to threat of denial of care, and verbal assault.

VPC – pursuant to LTCHA, 2007, S.O. 2007, c.8, s. 152(2) the licensee is hereby requested to prepare a written plan of correction to ensure that the home take appropriate action for all allegations of abuse for achieving compliance, to be implemented voluntarily.

Inspector ID#: 141

WN#2: The Licensee has failed to comply with: LTCHA 2007, S.O 2007, c. 8, s.6(10)(b)

The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary

Findings:

1. An identified resident's plan of care was not revised to incorporate a ordered treatment that was ongoing.

Inspector ID#: 141

WN#3: The Licensee has failed to comply with: LTCHA 2007, S.O 2007, c. 8, s.6(8)

The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it.

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé.

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.)

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

Findings:

1. An identified resident's plan of care was not accessible to give direction to staff that provide the direct care to the resident.

Inspector ID#: 141

WN#4: The Licensee has failed to comply with: LTCHA 2007, S.O 2007, c. 8, s.76(2)3

Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: (3)The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

Findings:

1. The home education records do not indicate that a staff person involved in an allegation of resident abuse had training related to abuse and resident's rights.

Inspector ID#: 141

WN#5: 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.

Findings:

1. Police were not notified of an allegation of physical abuse of a resident by a staff member.

Inspector ID#: 141

WN#6: The Licensee has failed to comply with: LTCHA 2007, S.O 2007, c. 8, s.3(1)2

Every licensee of a long-term care home shall ensure that the following rights of resident are fully respected and promoted: 2. Every resident has the right to be protected from abuse.

Findings:

1. There is no indication that a registered staff person communicated to other staff members that an identified resident's treatment was not completed. The procedure was completed when the resident informed another registered staff of the need. The resident in her interview stated she was frightened by the incident. The day after the incident the resident informed staff she did not sleep during the night because of the incident.

VPC – pursuant to LTCHA, 2007, S.O. 2007, c.8, s. 152(2) the licensee is hereby requested to prepare a written plan of correction in ensuring that all residents are protected from abuse,

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé.

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.)

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

for achieving compliance to be implemented voluntarily.

Inspector ID#: 141

CORRECTED NON-COMPLIANCE **Non-respectés à Corrigé**		
Signature of Licensee of Designated Representative **Signature du Titulaire du représentant désigné**		**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Charles McNally
Title:	**Date:**	**Date of Report (if different from date(s) of inspection).** January 7, 2011