Ministry of Health and Long-Term Care	Ministère de la Santé et des Soins de longue durée
Inspection Report under the Long-Term Care Homes Act, 2007	**Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue**

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 29, Jul 3, 4, 5, 10, 2012	2012_044161_0028	Complaint

Licensee/Titulaire de permis

458422 ONTARIO LIMITED
220 EMMA STREET, CORNWALL, ON, K6J-5V8

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

SANDFIELD PLACE
220 EMMA STREET, CORNWALL, ON, K6J-5V8

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

KATHLEEN SMID (161)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, a Registered Nurse, a Personal Support Worker and Resident # 001.

During the course of the inspection, the inspector(s) observed Resident # 001 and reviewed his/her health record.

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	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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 O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following subsections:

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 :

The licensee failed to comply with O. Reg 79/10 s. 97 (1)(b) in that a resident's substitute decision-maker was not notified within 12 hours upon the licensee becoming aware of a suspected incident of sexual abuse of the resident.

During an interview in June 2012 PSW # S103 indicated to the inspector that on an earlier date in June 2012 Resident #001 was lying in bed on his/her back, covered with a blanket, and his/her legs were slightly over the beds' raised left side rail. PSW #S103 observed the visitor of Resident #002 standing at the bedside of Resident #001. His/her hand was under the blanket at approximately the waist level of Resident #001.

When PSW #S103 intervened, the visitor of Resident #002 said he/she was trying to reposition Resident #001. He/she then left the resident's room.

During an interview in June 2012, Registered Nurse S#102 indicated to the inspector that on an earlier date in June 2012 she entered into the room of Resident #001 and PSW # S103 informed her of the behaviour of the visitor of Resident #002. Registered Nurse S#102 examined Resident #001 and noted that his/her continence brief was shifted towards his/her right side with some abdominal and pubic area exposed. There was no evidence of skin irritation.

During discussion with the home's Administrator, she indicated that the Resident # 001's substitute decision-maker was not notified within 12 hours upon the licensee becoming aware of a suspected incident of sexual abuse of the resident.

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 :

The licensee failed to comply with O. Reg 79/10 s. 98 in that they failed to immediately notify the police force of a suspected incident of sexual abuse.

A suspected incident of sexual abuse of Resident #001 by a visitor occurred in June 2012 and the police were not notified until the following day.

During an interview in June 2012 PSW # S103 indicated to the inspector that on an earlier date in June 2012 Resident #001 was lying in bed on his/her back, covered with a blanket, and his/her legs were slightly over the beds' raised left side rail. PSW #S103 observed the visitor of Resident #002 standing at the bedside of Resident #001. His/her hand was under the blanket at approximately the waist level of Resident #001.

When PSW #S103 intervened, the visitor of Resident #002 said he/she was trying to reposition Resident #001. He/she then left the resident's room.

During an interview in June 2012, Registered Nurse S#102 indicated to the inspector that on an earlier date in June 2012 she entered into the room of Resident #001 and PSW # S103 informed her of the behaviour of the visitor of Resident #002. Registered Nurse S#102 examined Resident #001 and noted that his/her continence brief was shifted towards his/her right side with some abdominal and pubic area exposed. There was no evidence of skin irritation.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following subsections:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

The licensee failed to comply with O. Reg 79/10 s. 104 (1) in that in making a written report to the Director under subsection 23 (2) of the Act, the licensee did not include an accurate description of the suspected incident of sexual abuse of a resident by a visitor.

During an interview in June 2012 Personal Support Worker (PSW) # S103 indicated to the inspector that earlier in June 2012 Resident #001 was lying in bed on his/her back, covered with a blanket, and his/her legs were slightly over the beds' raised left side rail. The PSW #S103 observed a visitor of Resident #002 standing at the bedside of Resident #001. The visitor's hand was under the blanket at approximately the waist level of Resident #001.

During an interview in July 2012 PSW #103 reiterated to the inspector that she observed the visitor of Resident #002 standing at the bedside of Resident #001. The visitor's hand was under the blanket at approximately the waist level of Resident #001.

In June 2012 the licensee submitted a Critical Incident Report to the Director. It indicates that "a staff member found a visiting family member not related to the resident with his/her hand down the pants of the resident."

During a discussion with the home's Administrator in July 2012, the Administrator indicated to the inspector that the home was in error of the description of the suspected incident of sexual abuse of a resident by a visitor. She indicated the Critical Incident would be revised for accuracy and resubmitted to the Director

Issued on this 13th day of August, 2012

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

Kathleen Smid