**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**Toronto Service Area Office**
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
Telephone: 1-866-311-8002
TorontoSAO.moh@ontario.ca

**Original Public Report**

**Report Issue Date** September 26, 2022
**Inspection Number** #2022_1254_0001
**Inspection Type**
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

**Licensee**
Smooth Rock Falls Hospital

**Long-Term Care Home and City**
Smooth Rock Falls Hospital, Smooth Rock Falls

**Lead Inspector**
Shelley Murphy #684

**Inspector Digital Signature**
Shelley Murphy
Digitally signed by Shelley Murphy
Date: 2022.10.11 11:27:02 -04'00'

## INSPECTION SUMMARY

The inspection occurred on the following date(s): September 6-8, 2022

The following intake(s) were inspected:

One intake related to resident abuse.

The following **Inspection Protocols** were used during this inspection:

- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect

## INSPECTION RESULTS

### WRITTEN NOTIFICATION REPORTING CERTAIN MATTERS TO DIRECTOR

**NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: LTCHA, 2007 *s. 24 (1) 2.***

The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or a risk of harm to the resident, was immediately reported to the Director.

**Rationale and Summary**
The home's Critical Incident System (CIS) submission to the Ministry of Long Term Care (MLTC) for the incident was submitted late.

During an interview with the Long Term Care (LTC) Manager they stated that the CIS report was submitted late.

This non-compliance had no risk to the residents.

**Sources:** CIS report, Staff interview, LTC Manager interview and the home's policy titled "Reporting of Mandatory and Critical Incident Requirement", Last reviewed July 2022.

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## WRITTEN NOTIFICATION-DUTY TO PROTECT

**NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: LTCHA, 2007 *s. 19 (1)***

The licensee has failed to ensure that a resident was protected from abuse by a member of the staff.

**Rationale and Summary**
Inspector reviewed investigation notes, several staff indicated that another staff member was inappropriate with some of the LTC residents and did not provide resident care as per the resident care plans.

One resident said they were uncomfortable with the care that the staff member provided.

The home investigation file was reviewed with the LTC Manager. The file contained documentation that supported the staff and resident concerns.

The actions of the employee caused minimal harm to a resident.

**Sources:**
Employee file, home's policy titled "Zero Tolerance of Abuse and Neglect Policy", Last revised June 2022, Investigation notes from the home, and employee interviews.

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