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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 17, 2019	2019_795735_0005	008291-18, 027186-18	Complaint

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Stirling Heights
200 Stirling Macgregor Drive CAMBRIDGE ON N1S 5B7

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

KRISTAL PITTER (735), MARIA MCGILL (728)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 1-5, 2019

The following intakes were completed in this Complaint inspection:

Log # 027186-18 related to prevention of abuse and neglect.
Log # 008291-18 related to sufficient staffing.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Interim Director of Care, a Dietary Aide, the Resident Assessment Instrument (RAI) Coordinator/Falls Lead, Registered Nurses, a Registered Nursing Student, Registered Practical Nurses, Personal Support Workers, a former Personal Support Worker, a family member, and residents.

The inspectors also made observations of residents and care provided. Relevant reports, policies and procedures, the home's investigation notes, resident assessments, as well as clinical records and plans of care for the identified residents were reviewed.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **1 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	Légende 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 alleged abuse of a resident by staff that resulted in risk of harm to the resident was immediately reported to the Director.

A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) regarding alleged verbal and emotional abuse of a resident by staff. Information concerning this was obtained from an interview with a complainant. The complainant indicated that they notified the home of the incident.

A review of the home's Critical Incidents (CI) submitted to the MOHLTC failed to locate a CI related to this specific allegation of abuse.

The home's investigative notes indicated that the Interim Director of Care (IDOC) was aware of the incident and initiated an investigation. The IDOC said that she was notified of the allegation of abuse, but did not report the allegation to the Director.

The licensee has failed to ensure that the IDOC, who had reasonable grounds to suspect abuse of a resident by staff, immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

Issued on this 18th day of April, 2019

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

Original report signed by the inspector.