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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 14, 2019	2019_689586_0013	015220-19	Critical Incident System

Licensee/Titulaire de permis

Mennonite Brethren Senior Citizens Home
1 Tabor Drive St. Catharines ON L2N 1V9

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

Mennonite Brethren Senior Citizens Home
1 Tabor Drive St. Catharines ON L2N 1V9

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

JESSICA PALADINO (586)

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): August 6 and 7, 2019.

The following Critical Incident System (CIS) inspection was completed: 015220-19 - Prevention of Abuse & Neglect.

During the course of the inspection, the inspector(s) spoke with the Interim Director (ID), Assistant Director of Care (ADOC), registered staff, recreation staff, personal support workers (PSW) and residents.

During the course of the inspection, the inspector reviewed clinical health records, internal investigation notes, employee records and policies and procedures.

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)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

During the course of this inspection, Administrative Monetary Penalties (AMP) were not issued.
- **0 AMP(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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

WN #1: 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 :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspected may constitute a criminal offence.

A) CIS report #C571-000016-19 was submitted to the Director on an identified date in 2019, outlining alleged resident abuse. The licensee did not contact the police until the following day. The Interim Director confirmed that the police were not immediately notified.

B) CIS report #C571-000009-19 was submitted to the Director on an identified date in 2019, outlining alleged resident abuse. Review of the CIS and interview with the ID confirmed that the police were not notified of this incident. The Interim Director confirmed that the police were not notified.

C). CIS report #C571-000009-18 was submitted to the Director on an identified date in 2018, outlining alleged resident abuse. Review of the CIS and interview with the ID confirmed that the police were not notified of this incident. The Interim Director confirmed that the police were not notified. [s. 98.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents dealt with any additional matters as may be provided for in the regulations, specifically O. Reg. 79/10, r. 98.

According to O. Reg. 79/10, r. 98, the appropriate police force must be 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.

The licensee's policy, 'Abuse' (last revised August 2018), did not include the need to notify the police of any alleged, suspected or witnessed abuse or neglect toward a resident.

On an identified date in 2019, a incident of alleged abuse was brought forward by the licensee, and the police were not notified until the following day. On another date in 2019 as well as a date in 2018, alleged abuse was reported to the licensee and the police were not notified of these incidents.

The Interim Director and ADOC acknowledged that the licensee's abuse and neglect policy did not include the requirement to notify the police. [s. 20. (2) (h)]

Issued on this 19th day of August, 2019

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

Original report signed by the inspector.