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
Mar 4, 2019	2019_644507_0006	002713-18, 006983-18, 008995-18, 010791-18	Critical Incident System

Licensee/Titulaire de permis

Don Mills Foundation for Seniors
1 Overland Drive TORONTO ON M3C 2C3

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

Thompson House
1 Overland Drive NORTH YORK ON M3C 2C3

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

STELLA NG (507), JOANNE ZAHUR (589)

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): February 21, 22, 25 and 26, 2019.

The following critical incident system reports were inspected concurrently with this inspection:
#002713-18 (CIS #C573-000002-18) related to staff to resident abuse, #006983-18 (CIS #C573-000004-18), #008995-18 (CIS #C573-000005-18) and #010791-18 (CIS #C573-000007-18) related to outbreak management.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing (DON), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Physiotherapist (PT) and Public Health Nurse.

The inspectors conducted observations of staff and resident interactions, provision of care, record review of resident and home records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that resident #002 was protected from abuse by anyone.

On an identified date, an identified critical incident system (CIS) report was submitted to the Ministry of Health and Long Term Care (MOHLTC) in regard to an abuse allegation against a staff member.

Review of the CIS report indicated the home received an email from resident #002's substitute decision-maker (SDM) two days prior informing the home that resident #002 told the family a staff member abused them.

Review of the CIS report and the home's investigation notes indicated that resident #002 described the alleged staff member to the SDM, and the home worked with the SDM to identify the alleged staff member. Three days after receiving the email from the SDM, the home appointed a third party to conduct the investigation of the alleged abuse. Police were notified of the alleged abuse.

Review of the third party investigation report completed on an identified date indicated an identified staff member admitted abusing resident #002.

Review of the identified staff member's employee file indicated that the staff was terminated on the day of the investigation conducted by the third party based on the outcome of the investigation of the alleged abuse.

Resident #002 was not residing in the home at the time of the inspection therefore, an interview was not conducted.

The identified staff member was no longer working in the home therefore, an interview was not conducted.

In an interview, staff #113 stated the identified staff member was terminated on the day the staff member admitted abusing resident #002. Staff #113 acknowledged resident #002 was not protected from abuse by staff, [s. 19. (1)]

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 all residents are protected from abuse by anyone., to be implemented voluntarily.

Issued on this 13th day of March, 2019

[redacted]

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

Original report signed by the inspector.