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
Jun 5, 2019	2019_730593_0011	007531-19	Complaint

Licensee/Titulaire de permis

Township of Osgoode Care Centre
7650 Snake Island Road METCALFE ON K0A 2P0

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

Township of Osgoode Care Centre
7650 Snake Island Road METCALFE ON K0A 2P0

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

GILLIAN CHAMBERLIN (593), JANET MCPARLAND (142)

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 15 - 18, 23 - 24, 2019.

Complaint log #007531-19 was inspected, related to allegations of staff to resident physical abuse. A Critical Incident (CIS) log #007607-19 (2747-000003-19) related to the same incident, was also completed during this complaint inspection. Non-compliance was identified as a result of this CIS and is captured in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), the Physiotherapist (PT), Registered Nursing staff, Personal Support Workers (PSW), residents and family members.

The Inspector observed the provision of care and services to residents, resident's environment, staff to resident interactions, reviewed resident health care records, licensee investigation records and education records.

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.

- **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 a person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to resident #001, has immediately reported the suspicion and the information upon which it is based to the Director.

A critical incident report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC), reporting the alleged physical abuse of resident #001. It was reported in the CIS that resident #001 was discovered with fractures of unknown origin.

As per the CIS, resident #001 was sent to hospital for an unrelated health concern. The orthopedic surgeon from the hospital called the home the following day requesting more information related to resident #001's sustained injuries. The home were unaware of these injuries as the resident was sent to the hospital for a different reason. Two days later, Ottawa Police arrived at the home at 1345 hours to inform the home that the family were concerned about findings from the hospital. The Police stated that the resident had several fractures. A CIS was submitted to the Director that afternoon.

A review of resident #001's progress notes found the following entry related to the incident:

At 1130 hours, a orthopaedic surgeon from the hospital called. The surgeon informed

RPN #119 that resident #001has several fractures and was inquiring if the resident had fallen. After this phone call, a member of resident #001's family called requesting specific information, RPN #119 informed the family member that they were unable to provide that kind of information but does not believe that resident #001 fell. The family member replied that they suspected that resident #001 was dropped. RPN #119 informed the DOC.

During an interview with Inspector #593, April 24, 2019, the Executive Director indicated that they were on vacation when the incident occurred and when the orthopedic surgeon and family member called the home, the nurse reported the information to the DOC. The Executive Director indicated that the DOC upon receiving that information, should have reported it to the Director immediately.

The licensee became aware of suspicions of abuse toward resident #001. It was not until the police arrived on two days later, that the home made the decision to submit a CIS to the Director, which they did, more than 48 hours after the home were first aware of suspicions of abuse. As such, the licensee has failed to ensure that when a person who has reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to a resident, has immediately reported the suspicion and the information upon which it is based to the Director. (log #007531-19, #007607-19) [s. 24. (1)]

Issued on this 5th day of June, 2019

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

Original report signed by the inspector.