Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
Aug 23, 2019	2019_577611_0024	030407-18, 011550-19, 012976-19	Complaint

Licensee/Titulaire de permis

United Mennonite Home for the Aged
4024 Twenty-Third Street Vineland ON L0R 2C0

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

United Mennonite Home
4024 Twenty-Third Street Vineland ON L0R 2C0

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

KELLY CHUCKRY (611)

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): August 14, 15, and 16, 2019

PLEASE NOTE: This complaint inspection was conducted concurrently with CIS inspection # 2019_577611_0025 / 002594-18, 015238-19, 015963-19.

During the course of the inspection, the inspector(s) observed the provision of resident care, reviewed relevant clinical health records, investigative notes, and relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with residents in the home, the Director of Care, (DOC), the Resident Assessment Instrument (RAI)/Wound Care Coordinator, Registered Nurses (RNs), Registered Practical Nurses, (RPNs), Personal Support Workers, (PSWs), and dietary aides.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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 failed to ensure that all residents were protected from abuse by anyone.

In June 2019, a complaint was submitted, Log #011550-19, pertaining to resident #006. In addition, in August 2019, the licensee submitted a CIS report # CI 2951-000009-19, which indicted that on an identified date, the home was investigating an incident between staff #101, and resident #006.

The investigation notes were reviewed as part of this inspection. On an identified date, staff #102 was speaking with resident #006. During this discussion, staff #101 entered the area and observed an incident between resident #006 and staff #101.

This incident was further witnessed by staff #103 and #104.

Interviews were conducted with staff #102, #103, and #104 and indicated that this interaction was inappropriate.

In an interview conducted with the DOC, it was confirmed that this interaction was a form of abuse by staff #101 towards resident #006. [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.

WN #2: 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 failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, did not immediately report the suspicion and the information upon which it was based to the Director: 2. 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 the resident.

In June 2019, a complaint was submitted, Log #011550-19, pertaining to resident #006. In addition, in August 2019, the licensee submitted a CIS report # CI 2951-000009-19, which indicated that on an identified date, the home was investigating an incident between staff #101, and resident #006.

The investigation notes were reviewed as part of this inspection. On an identified date, staff #102 was speaking with resident #006 when an incident between resident #006, and staff #101 took place.

The incident was further witnessed by staff #103 and #104.

This incident, that occurred on an identified date, was not immediately reported to the Ministry of Health and Long Term Care.

The home had a policy entitled Resident Abuse 4.01 with a revision date of September 2018. The policy indicated that "the home will report to the MOHLTC Director the results of every investigation the home conducts under this policy, and any action the home takes in response to any incident of resident abuse or neglect". The policy further states that abuse of a resident by anyone or neglect of a resident that resulted in harm or risk of harm to a resident shall immediately report the suspicion and the information upon which it is based to the Director.

In an interview conducted with the DOC it was confirmed that this interaction was a form of abuse by identified staff #101 towards resident #006, and the incident was not immediately reported to the Director. [s. 24. (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 the person who ha 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 was based to the Director: 2. 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 the resident, to be implemented voluntarily.

Issued on this 16th day of September, 2019

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

Original report signed by the inspector.