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
Sep 24, 2019	2019_541169_0021	002881-19, 002988-19	Complaint

Licensee/Titulaire de permis

Parkview Meadows Christian Retirement Village
72 Town Centre Drive Townsend ON N0A 1S0

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

Gardenview Long Term Care Home
72 Town Centre Drive Townsend ON N0A 1S0

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

YVONNE WALTON (169)

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): September 16, 17 and 19, 2019

The following complaints were inspected related to abuse: 02881-19 and 02988-19.

During the course of the inspection, the inspector(s) spoke with Assistant Directors of Care (3) (ADOC), Physiotherapist (PT), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSW), Residents and Families.

During the course of the inspection, the inspector observed care areas, meal service. The inspector reviewed clinical records, home's abuse policy, minutes of meetings, reviewed staffing schedules and resident incident reports.

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)**
- **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 has failed to ensure that resident #001 was protected from abuse by staff in the home.
This inspection has been initiated as a result of a complaint received related to abuse of a resident by a staff member.

Resident #001 was the victim of abuse. This altercation resulted in an injury to the resident.
Documentation provided by the home confirmed abuse occurred toward resident #001. The licensee also submitted a critical incident to the Ministry of Health and Long Term Care that confirmed abused had occurred. This was also confirmed during an interview with PSW#105 and interviews with the ADOC.

The licensee failed to protect resident #001 from abuse by a staff member at the home. [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 that ensures the licensee of a long-term care home protects residents from abuse by anyone and ensures that residents are not neglected by the licensee or staff, 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. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's Abuse Policy, revised September 2018, was complied with.

The home's policy named "Abuse Policy," revised September 2018, was reviewed and directed the staff to do the following:

A) Report any witnessed or suspected abuse of a resident, or who received complaints of abuse, should report the matter immediately to the Administrator (or delegate) of the Long Term Care Facility and directed staff that have witnessed abuse to assess the resident or victim, provide immediate care and report promptly to the most senior administrative personnel on site.
B) The most senior administrative staff or delegate will assess the resident and determine any injury, and provide immediate care.
C) The pertinent information shall be documented in the resident's record.

Resident #001 was the victim of abuse. PSW #105 did not report the witnessed abuse to the Administrator immediately and waited 6 days. This was confirmed by interview with ADOC and PSW #105. PSW #105 did not follow the abuse policy, that directed staff to immediately report the incident to the Administrator (or delegate).

The policy also directed the most senior administrative staff or delegate to assess the resident and determine any injury, and provide immediate care.
The licensee did not provide immediate care to the resident, nor did they assess the extent of their injuries. This was confirmed during an interview with the ADOC.

The policy directed staff to document pertinent information in the resident's record. A review of the resident's clinical record did not indicate abuse of any kind had occurred. This was confirmed during an interview with the ADOC.

The licensee failed to ensure the home's abuse policy was complied with. [s. 20. (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 that ensures there is a in place a written policy to promote zero tolerance of abuse and neglect of residents, and ensures that the policy is complied with, to be implemented voluntarily.

Issued on this 25th day of September, 2019

[redacted]

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

Original report signed by the inspector.