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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 2, 2014	2014_380593_0002	S-000213-14	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

PINEWOOD COURT
2625 WALSH STREET EAST, THUNDER BAY, ON, P7E-2E5

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

GILLIAN CHAMBERLIN (593)

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): July 9th - 10th, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Registered Nursing Staff, Personal Support Worker's (PSW), Administrative Staff, Residents and Residents' family members.

During the course of the inspection, the inspector(s) observed the provision of care and services to Residents, observed staff to Resident interactions, reviewed Resident health care records, reviewed staff training records and reviewed home policies on the protection of Residents from abuse and neglect.

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

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. This non-compliance is supported by the following findings:

A review of the home's abuse policy identified that any staff member or person, who becomes aware of and / or has reasonable grounds to suspect abuse or neglect of a Resident must immediately report that suspicion and the information on which it is based to the executive director of the home or the most senior supervisor on shift at that time, in addition any person who has reasonable grounds to suspect that abuse of a resident has occurred, must immediately report the suspicion and the information upon which it is based to the Director of the Ministry of Health and Long-Term Care.

During an interview with Inspector #593 July 9, 2014 at 15:20, staff member #102 advised that on the evening of May 13, 2014 at approximately 22:00, they found Resident #001 upset in their room with the door closed. Resident #001 reported to staff member #102 that earlier that evening staff had removed their call bell and slammed the door on the way out of their room. Resident #001 further advised that another staff member had been rough with them during their bath and now their arms were sore from being roughly handled. Staff member #102 reported this to staff member #110. Staff member #102 and staff member #110 did not report these allegations of abuse any further.

During an interview with Inspector #593 July 10, 2014 at 09:20, Staff member #110 advised that they do not remember the events of the evening of May 13, 2014 and do not remember staff member #102 reporting the abuse allegations to them.

During an interview with Inspector #593, the home's Administrator staff member #105 advised that Resident #001 reported the incident to family member #006 May 14, 2014. Family member #006 immediately reported the incident to staff member #104 who further reported the incident to the home's Administrator staff member #105. This critical incident was then reported to the Director of the Ministry of Health and Long-Term Care by the Administrator of the home staff member #105.

The licensee of Pinewood Court submitted a critical incident report for this critical incident involving alleged abuse by staff member #100 towards Resident #001. This critical incident report was submitted on May 14, 2014 at 16:46 however staff within the home were first made aware of the abuse allegations the previous day May 13, 2014 at 22:00. As such, the licensee has failed to immediately report the abuse of a resident to the Director as required in the legislation. [s. 24. (1)]

Issued on this 24th day of October, 2014

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