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_648741_0002	031417-18, 031820-18, 031824-18, 032560-18, 000654-19	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

McGarrell Place
355 McGarrell Drive LONDON ON N6G 0B1

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

AYESHA SARATHY (741), CHRISTINA LEGOUFFE (730), HELENE DESABRAIS (615)

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 19, 20 and 21, 2019

The following Critical Incident (CI) reports were inspected during the course of this inspection:

Log # 031417-18/CI 2964-000084-18 related to allegations of resident to resident physical abuse
Log # 031820-18/CI 2964-000087-18 related to allegations of resident to resident physical abuse
Log # 031824-18/CI 2964-000088-18 related to allegations of resident to resident sexual abuse
Log # 032560-18/CI 2964-000090-18 related to allegations of resident to resident physical abuse
Log # 000654-19/CI 2964-000001-19 related to allegations of resident to resident sexual abuse

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Behavioural Supports Ontario (BSO) workers, the Quality Manager (QM), the Executive Director (ED) and residents.

During the course of the inspection, the inspector(s) also reviewed medical records and plans of care for identified residents, reviewed relevant policies and procedures of the home and internal investigation notes.

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

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. 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 to report to the Director a suspicion of abuse of a resident that resulted in harm or a risk of harm to the resident.

On a specified date, the home submitted a Critical Incident System report to the Ministry of Health and Long-Term Care (MOHLTC) regarding the alleged physical abuse of an identified resident to another resident, resulting in swelling to the affected area.

A review of the identified resident's progress notes in Point Click Care (PCC) showed that the resident was found by a staff member hitting another resident repetitively with a closed fist. In an interview with a Registered Practical Nurse (RPN), they stated that the identified resident had a history of responsive behaviours, had been referred to the Behavioural Response Team and was already being followed by the Behaviour Supports Ontario program. The RPN said that the incident was unprovoked and witnessed by a staff member.

A review of the Risk Management section in PCC showed that this incident was entered into the system as a resident to resident altercation. During an interview, the Quality Manager said that the home was aware of the incident and had entered it into Risk Management.

During an interview, an RPN was asked if they would report an incident to the MOHLTC in which they found a resident punching another resident without any resulting visible traces or injuries. They stated that they would report it because an injury could develop over time.

In an interview with the Administrator, they said that a resident punching another resident constituted abuse. They said that the altercation between the two residents was not reported to the MOHLTC and should have been as there were reasonable grounds to suspect abuse.

The licensee failed to ensure to report suspected abuse of a resident which resulted in risk of harm to the resident 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 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: 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., to be implemented voluntarily.

Issued on this 5th day of March, 2019

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

Original report signed by the inspector.