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 12, 2019	2019_779641_0003	029788-18, 030495-18, 031619-18, 032071-18, 032154-18, 033501-18, 000363-19	Critical Incident System

Licensee/Titulaire de permis

AON Inc.
307 Aylmer Street PETERBOROUGH ON K9L 7M4

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

Moira Place Long-Term Care Home
415 River Street West P.O. Box 200 TWEED ON K0K 3J0

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

CATHI KERR (641)

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 8, 14, 15, 19, 20, 21 and 22, 2019.

This inspection was conducted in reference to critical incident Log #033501-18, CIS #2977-000044-18; #032154-18, CIS #2977-000041-18; #032071-18, CIS #2977-000040-18; #031619-18, CIS #2977-000039-18; #030495-18, CIS #2977-000038-18 and #000363-19, CIS #2977-000001-19 related to suspected alleged abuse or neglect; and Log #029788-18, CIS #2977-000037-18 related to a fall causing injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Life Enrichment Aides, and residents.
During the course of the inspection, the Inspector reviewed resident care and services, staff to resident and resident to resident interactions, reviewed resident health care records and Critical Incident System reports (CIS) and relevant licensee investigation notes.

The following Inspection Protocols were used during this inspection:
Falls Prevention
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 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 has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

This finding was in reference to intake log #033501-18 and CIS #2977-000044-18. Inspector #641 reviewed CIS #2977-000044-18 and noted that the incident of suspected or alleged abuse occurred on a specified date and had been reported to the Director a day and a half later.

During an interview with Inspector #641 on February 20, 2019 at 1120 hours, the Director of Care (DOC) indicated that when there was an incident of suspected abuse during the off hours, when the Administrator, DOC or ADOC were not in the home, it was the responsibility of the supervising nurse to call the Ministry of Health and Long-Term Care's after hours pager to report the suspected abuse. The DOC advised that in this incident, the supervisor had not followed the licensee's protocol to call the after hour pager at the time of the incident. [s. 24. (1)]

2. This finding was in reference to intake log #030495-18 and CIS #2977-000038-18. Inspector #641 reviewed CIS #2977-000038-18 and noted that the alleged incident of abuse occurred on a specified date and it had been submitted to the Director 11 days later.

During an interview with Inspector #641 on February 20, 2019 at 1120 hours, the DOC indicated that in this incident, the supervisor had not followed the protocol to call the Ministry of Health and Long-Term Care's after hours pager and had not reported the incident to the DOC or ADOC. The DOC advised they had only become aware of the incident later on in the month.

The licensee failed to ensure that when a staff had reasonable grounds to suspect an abuse of a resident, the supervisor did not immediately report the suspicion and the information upon which it was based 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 abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

Issued on this 12th day of March, 2019

[redacted]

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

Original report signed by the inspector.