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 |
|---|---|---|---|
| May 27, 2014 | 2014_262523_0015 | L-000311-14 | Complaint |

**Licensee/Titulaire de permis**

Oneida Nation of the Thames
2212 Elm Avenue, R. R.#2, SOUTHWOLD, ON, N0L-2G0

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

Oneida Nation of the Thames Long-Term Care Home (Tsi' Nu: yoyantle' Na' Tuhuwatisni)
2212 Elm Avenue, R. R.#2, SOUTHWOLD, ON, N0L-2G0

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

ALI NASSER (523)

## 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): May 8, 2014**

**During the course of the inspection, the inspector(s) spoke with the Business Manager (co-acting Administrator), Activities Manager (co-acting Administrator), Resident Service Manager, Registered Staff and Resident**

**During the course of the inspection, the inspector(s) reviewed critical incident report, clinical records, plan of care, policies and procedures and observed Resident care areas**

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

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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 a Resident was not neglected by staff.
A Registered Staff arranged transportation by taxi to an appointment for a Resident who has memory loss and cognitive impairment. The Registered Staff sent the Resident out of the home unaccompanied placing the resident at risk due to his cognitive impairment. The Registered Staff called the clinic at around 1700 hours as Resident was not back home yet, the clinic was closed.
The police found the Resident intoxicated in a park, the Resident was taken to hospital and brought back home on the next day.
The co-acting Administrators confirmed that the Resident was not safe to leave the home alone and also confirmed that it is the Home's expectations that Residents would be assessed and then determined if it is safe for them to leave the home alone. [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 ensuring that Residents are not neglected by the licensee or staff, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act**

**Specifically failed to comply with the following:**

**s. 23. (1) Every licensee of a long-term care home shall ensure that,**
**(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:**
**(i) abuse of a resident by anyone,**
**(ii) neglect of a resident by the licensee or staff, or**
**(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).**
**(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).**
**(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).**

**Findings/Faits saillants :**

1. The Licensee has failed to ensure that an incident of alleged neglect was immediately investigated.

The Home's co-acting Administrators were not able to provide proof that the incident was investigated.

The co-acting Administrators both confirmed that it is the Home's expectations that every alleged, suspected or witnessed incident of neglect should be immediately investigated. [s. 23. (1) (a)]

***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 ensuring that every alleged, suspected or witnessed incident of neglect of a Resident by licensee or staff is immediately investigated, to be implemented voluntarily.***

**Issued on this 27th day of May, 2014**

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

ALI NASSER