

**Inspection Report under
the Long-Term Care
Homes Act, 2007****Rapport d'inspection en vertu de
la Loi de 2007 sur les foyers de
soins de longue durée****Long-Term Care Operations Division
Long-Term Care Inspections Branch****Division des opérations relatives aux
soins de longue durée
Inspection de soins de longue durée**Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015Bureau régional de services de Centre
Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015**Public Copy/Copie du rapport public**

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 8, 2020	2019_826606_0029	019350-19, 021511- 19, 022582-19	Critical Incident System

Licensee/Titulaire de permisThe Regional Municipality of Peel
10 Peel Centre Drive Suite B, 3rd Floor BRAMPTON ON L6T 4B9**Long-Term Care Home/Foyer de soins de longue durée**Peel Manor
525 Main Street North BRAMPTON ON L6X 1N9**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

JANET GROUX (606)

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): December 19, 20, and 23, 2019.

The following Intakes were inspected:

Log #021511-19 regarding an allegation of staff to resident physical abuse; log #022582-19 and #019350-19 regarding allegations of staff to resident emotional abuse.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Supervisors of Care (SOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

The Inspector also toured resident living areas; observed resident-staff interactions; reviewed relevant clinical records, investigation records, staff training records and policies and procedures.

**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.

3 WN(s)

3 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care with regards to their care needs was provided to resident #003 as specified in the plan of care.

A Critical Incident (CI) reported an alleged incident of staff to resident emotional abuse.

Resident #003 told the Long Term Care Homes (LTCH) Inspector that Personal Support Worker (PSW) #109 made comments during care that made them feel abused and that they had concerns about the care they received from the PSW. Resident #003 said that they required an identified activity of daily living (ADL) to be provided at a specified time. They stated that PSW #109 did not follow their plan of care and when they informed them of their plan of care, PSW #109 refused to follow it. The Director of Care (DOC) confirmed that PSW #109 did not follow resident #003's plan of care.

The licensee failed to ensure that resident #003 was provided care as specified in their plan of care. [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan of care, to be implemented voluntarily.

WN #2: 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 residents were protected from emotional abuse.

For the purposes of the definition of “abuse” in subsection 2 (1) of the Act, “emotional abuse” means, (a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A CI reported an alleged incident of staff to resident emotional abuse. The CI stated that resident #003 told the DOC that PSW #109 made comments during care that they considered abusive.

Resident #003 told the LTCH Inspector that PSW #109 made comments during care that made them feel abused and which was upsetting to them.

The home's investigation of the incident validated that PSW #109's comments were emotionally upsetting to resident #003.

The licensee has failed to ensure that resident #003 was protected from emotional abuse from PSW #109 [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 to ensure that residents are protected from emotional abuse, to be implemented voluntarily.

WN #3: 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 policy which promoted zero tolerance of abuse and neglect of residents was complied with.

A CI reported an allegation of staff to resident verbal and physical abuse. The CI report stated that a staff member made derogatory comments to resident #001 and physically abused the resident.

The home's policy to promote zero tolerance of abuse and neglect of residents stated that any person who had witnessed or had reasonable grounds to suspect abuse or neglect of a resident must immediately make a report to the centre's Administrator/designate.

PSW #105 stated that on an identified date they witnessed staff member #102 make derogatory comments to resident #001 and physically abuse the resident. The PSW acknowledged that they did not report the incident to management until a number of days after.

The licensee failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents in relation to reporting 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 to ensure that the home's policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

Issued on this 15th day of January, 2020

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

Original report signed by the inspector.