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
Jan 17, 2013	2012_210169_0001	H-001901-12	Critical Incident System

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF PEEL
10 PEEL CENTRE DRIVE, BRAMPTON, ON, L6T-4B9

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

SHERIDAN VILLA
2460 TRUSCOTT DRIVE, MISSISSAUGA, ON, L5J-3Z8

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

YVONNE WALTON (169)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 30, 21 2012

This inspection refers to Log#H-1901-12.

During the course of the inspection, the inspector(s) spoke with the Administrator, nursing staff and the Supervisor of Behavioural Support.

During the course of the inspection, the inspector(s) reviewed the home's policy related to abuse, investigative documentation, clinical records and observed a care area.

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	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 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 did not ensure the home's policy LTCI-05.01 "Prevention, reporting and elimination of abuse and neglect" was complied with. Resident #1 was abused by a Personal Support Worker during care. Another staff member observed this abuse and reported it to the Registered Practical Nurse (RPN). The RPN assessed the resident and no injury was noted, however did not report the incident verbally or in writing, according to the home's policy.

The policy stated that "on becoming aware of abuse or suspected abuse, the person(s) first having knowledge of this shall immediately inform the Supervisor, or if not available, the Registered Nurse IN-Charge. The Administrator and Medical Director will be immediately notified of the incident." The notification to the Registered Nurse IN-Charge, Administrator and Medical Director did not occur until one day after the incident.

The policy stated that "the person first having knowledge of the abuse shall immediately prepare a signed, dated statement indicating all information witnessed or acquired after verbally reporting the incident." The RPN did not verbally report or document anything in the resident's clinical record to indicate abuse had occurred or the actions taken in response to the abuse. The RPN did not follow the home's policy. [s. 20. (1)]

Issued on this 17th day of January, 2013

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