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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 1, 2, 2016	2016_199626_0022	011012-15; 024798-16;19092-16	Critical Incident System

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

BALLYCLIFFE LODGE NURSING HOME
70 STATION STREET AJAX ON L1S 1R9

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

DENISE BROWN (626)

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): August 16 -17 and 22 -25, 2016

During the course of the inspection the following Critical Incidents were inspected: #011012-15, #019092-16 and #024798-16

Summary of intakes:
1. 011012-15 regarding resident to residents abuse
2. 019092-16 regarding resident to residents abuse
3. 024798-16 regarding resident to residents abuse

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

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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	Legendé 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 :

The licensee has failed to ensure that the person who had reasonable grounds to suspect that any abuse of a resident by any one has occurred or may occur, shall immediately report the suspicion of the abuse and the information upon which it was based to the Director. s.24 (1)

A review of the Licensee's policy titled Abuse Free communities-Prevention, Education and Analysis directs under:

Definition or Terms of Reference:
"Mandatory reporting by all persons" means all persons (i.e. employees, volunteers, family members, Substitute Decision Makers (SDMS), Power of Attorney (POA), Long Term Care Home Staff, and Long Term Care Home Operators), who have reasonable grounds to suspect the occurrence of any of the following events, either presently or in the near future are legally obligated to immediately report the suspicion and the information upon which it is based to the regulatory bodies including MOHLTC, Director; Regional Health Authorities, and other provincial licensing/certification authorities. Events include:
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.

Policy:
Education: All Employees and contracted service providers will be educated on abuse and abuse prevention prior to performing resident care or having contact with residents (orientation). Annually, Employees will, as part of their annual performance appraisal, be required to confirm in writing that they have reviewed and understood this policy as well as the policy on Abuse Allegations.

Under the section titled Procedure and subsection of Education Content outlined:
• An explanation of the duty of persons to report all matters specified to their Regulatory body following methods of reporting and required timelines.
• When to call police; only may determine if an act or action is of a criminal nature; A person's responsibilities when abuse is suspected include:
• Mandatory reporting obligations of all staff to the required provincial authority-this includes when and how to make the report.

Related to Intake Log #019092-16 for resident #001 and #003:

A Critical Incident Report (CIR) was submitted to the Director on a specified date three days after the incident of an allegation of resident to resident physical abuse. After hours notification was provided to the Director on a specified dated two days after the incident. As a result of the alleged abuse, resident #001 indicated being injured by resident #003. The CIR noted that the incident occurred on specified date, two days before it was reported to the Director.

During an interview with RN #112, the staff was uncertain if the incident was reported to the DOC on the following day after the incident had occurred. In another interview, the DOC indicated that RN #112 did not report the incident to the Director when it occurred. During the same interview, the DOC indicated being informed of the incident on return to work two days later and had reported it the Director at that time.

The licensee failed to immediately notify the Director of the alleged resident to resident physical abuse. [s. 24. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

The licensee has failed to ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98

Related to Intake Log #024798-16 for resident #001 and #003:

A Critical Incident Report was submitted to the Director on a specified date for an allegation of resident to resident physical abuse which resulted in injury. After hours notification was provided to the Director on the day of the incident. Resident #001 sustained an injury as a result of the alleged abuse involving resident #003. The CIR did not indicate that the police were notified of the incident.

An interview with the Administrator four days after the incident, confirmed that the police were not notified and would be informed at that time. During another interview, the DOC indicated that the RN who worked on the day that the incident occurred did not notify the police. The DOC in the same interview also indicated, that the incident took place on the weekend and the DOC did not notify the police upon return to work when made aware. The amended CIR dated five days after the incident, indicated that the police were notified by the licensee four days post-incident.

The licensee failed to immediately notify the police of an alleged resident to resident physical abuse. [s. 98.]

2. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. Reg. 79/10, s. 98

Related to Intake Log #019092-16 for resident #001 and #003:

A Critical Incident Report was submitted to the Director on a specified date three days after the incident of an allegation of resident to resident physical abuse. As a result of the alleged abuse, resident #001 indicated being injured by resident #003. The CIR noted that the incident was not reported to the police.

In an interview with the DOC, when asked why the police were not notified, the DOC indicated that the home suspected that resident #001's injury was self-inflicted. Resident #001 reported to the Quality Nurse that resident #003 was the person who caused the injury. The DOC also indicated in the same interview that the investigation findings did not verify that resident #003 was the resident involved. The DOC also indicated that the police were not notified after the Quality Nurse was informed.

The licensee failed to immediately notify the police of an alleged resident to resident physical abuse. [s. 98.]

Issued on this 2nd day of September, 2016

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

Original report signed by the inspector.