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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 28, 2015	2015_303563_0027	002973-15	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

Chartwell Aylmer Long Term Care Residence
465 TALBOT STREET WEST AYLMER ON N5H 1K8

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

MELANIE NORTHEY (563)

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): July 17 - 23 and 27, 2015

This Critical Incident # 2740-000002-15 was inspected during the Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, one Registered Practical Nurse, one Dietary Aide, two Personal Support Workers (PSWs) and the PSW Coordinator.
The inspector(s) also made observations, reviewed the home's investigation records, health records, policies and other relevant documentation.

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)**
- **2 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the "Critical Incident Report (CIS)" Policy put in place is complied with.

Record review of the Home's Policy No: LTC-CA-ON-100-05-04 titled: 05-Risk Management, Subject: Critical Incident Report (CIS), Revised November 2014 revealed, "Critical incidents that require immediate notification include: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident." "In the event a critical incident occurs, the staff member witnessing or becoming knowledgeable of the incident are to notify the Registered Staff in charge of the unit and/or their immediate supervisor."

Interview with the Director of Care (DOC) confirmed she was first was made aware of the critical incident involving Resident # 055 and Personal Support Worker (PSW) # 1 on February 17, 2015 and confirmed the critical incident was first documented by PSW # 1 on February 6, 2015.

Record review of the Critical Incident (CI) # 2740-000002-15 revealed:
CI Date and Time: February 20, 2015 at 1330 hours
Time CI first Submitted to Ministry of Health (MOH): February 23, 2015 at 1559 hours

The policy also states, "For critical incidents involving residents, registered staff will assess the resident and determine if emergency services need to be called, notify the Director of Care or designate of the situation, complete the resident incident report in the Risk Management Module of PointClickCare, and document the specific details and facts of the incident in progress notes in the resident chart."

Record review of the progress notes, assessments and risk management incident reporting in PointClickCare for Resident # 013, # 042, # 055, #056 and #057 revealed there was no documentation related to any of the identified critical incidents. [s. 8. (1) (b)]

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 "Critical Incident Report (CIS)" Policy put in place is complied with, to be implemented voluntarily.

WN #2: 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).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with.

Record review of the "Risk Management" Policy No: LTC-CA-ALL-100-05-02 with subject title: "Resident Abuse-Abuse Prevention Program- Whistle-Blowing Protection" last revised on October 9, 2014 revealed, "Abuse reporting is mandatory; all staff members are required to report any abuse, suspected abuse or allegation of abuse immediately to their respective supervisor. Failure to report abuse of any kind is subject to disciplinary action." "All reports of an abuse allegation are to be investigated immediately by the supervisor who receives the report." "In EACH and EVERY case of alleged/witnessed abuse all persons in the home are obliged and required to immediately report their observation/suspicion to their respective supervisor or the supervisor on duty. When a staff member receives a report of or observes anyone (staff member, volunteer, family member, visitors or residents) abusing a resident in any manner, staff will separate resident and abuser, ensure the resident is safe- immediately report the abuse to the DOC or designate."

Record review of the home's investigation notes revealed the following:
a) Interview between PSW # 1 and the PSW Coordinator revealed PSW # 1 had concerns related to PSW # 2.
b) Interview between PSW # 3 the PSW Coordinator revealed the PSW witnessed a critical incident involving PSW # 2 and Resident # 056. The PSW Coordinator also documented that she herself has witnessed critical incidents involving PSW # 2 and other residents.
Both interview dates did not mention the actual date the allegations of abuse occurred.

Record review of the home's investigation notes revealed the DOC had an interview with PSW # 1 where by the PSW shared a critical incident involving Resident # 055 and PSW # 2. Interview with the DOC confirmed she was first was made aware of the critical incident involving Resident # 055 by PSW # 1 several days after the incident and shared that PSW # 1 had also revealed that she had personal documentation of other incidents involving PSW # 2.

Record review of the photocopied personal documentation of PSW # 1 revealed the actual names of the residents were used:
a) critical incident involving Resident # 042 during personal care
b) critical incident involving Resident # 013 during personal care and
c) critical incident involving Resident # 042 during a transfer.

Record review of the home's investigation notes revealed the DOC had an interview with PSW # 3 on where by the PSW shared that Resident # 056 was involved in a critical incident with PSW # 2.

The policy regarding the required reporting of any abuse, suspected abuse or allegation of abuse immediately to the respective supervisor was not complied with by PSW # 1 who had documented concerns but did not report the suspected abuse to the PSW Coordinator until five days later and did not report the critical incident involving Resident # 055 to the Director of Care (DOC) until nine days later. The PSW Coordinator did not report the critical incidents to the DOC the day they occurred and the DOC did not report the allegations to the Ministry of Health (MOH) until six days after PSW # 1 reported the incidents to the DOC.

Staff interview with the PSW Coordinator confirmed there were complaints from staff about PSW # 2 three to four days prior to the PSW Coordinator's conversations with PSWs # 1 and # 3. The PSW Coordinator confirmed her incident notes were given to the DOC the day after the documented interviews with PSW # 1 and #3. Staff interview with the DOC revealed she could not recall the date in which she received the documentation from the PSW Coordinator.

Record review of the home's investigation notes revealed various documentation demonstrating critical incidents involving PSW # 2. PSW # 2 continued to work with further allegations thirteen days after the first documented critical incident.

The Administrator confirmed PSW # 1 did not receive re-education or discipline related to not reporting of abuse immediately. The policy regarding failure to report abuse of any kind would be subject to disciplinary action was not complied with for PSW # 1. Record review of the "Mandatory Education Self-Guided Learning Package" revealed staff are to report immediately to their supervisor, speak to someone directly, or report directly to the MOH. [s. 20. (1)]

2. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents shall contain an explanation of the duty under section 24 of the Act to make mandatory reports.

Record review of the home's policy No: LTC-CA-ALL-100-05-02, Titled: Risk Management, Subject: Resident Abuse-Abuse Prevention Program- Whistle-Blowing

Protection, Revised October 9, 2014 revealed the explanation of the duty under section 24 of the Act to make mandatory reports was absent. The policy states the "initial abuse report to the Ministry of Health (MOH) the day of the incident or next business day following incident … full investigation report and summary on Critical Incident Report to MOHLTC."

The duty under section 24 to make mandatory reports states, "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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident."

The home's policy to promote zero tolerance of abuse did not include specific reporting information required in the Act. [s. 20. (2)]

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 there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with and that the policy to promote zero tolerance of abuse and neglect of residents shall contain an explanation of the duty under section 24 of the Act to make mandatory reports, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the report to the Director included the following description of the individuals involved in the incident:
(i) names of all residents involved in the incident,
(ii) names of any staff members or other persons who were present at or discovered the incident, and
(iii) names of staff members who responded or are responding to the incident.

Record review of the Critical Incident (CI) # 2740-000002-15 on July 22, 2015 revealed the CI was submitted on February 23, 2015 for both Residents #013 and #042, excluding Resident #055, #056 and #057.

Record review of the home's investigation notes and other documentation revealed six staff members who documented or reported critical incidents involving multiple residents and PSW # 2. The CI had a description of the names of only three staff members.

The DOC confirmed on July 23, 2015 that the CI should have the names of all residents and staff involved in the incident. [s. 104. (1) 2.]

Issued on this 28th day of August, 2015

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

Original report signed by the inspector.