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 prévue 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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 25, 2019	2019_766500_0017	008578-17, 010551-18, 012828-18, 001186-19	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 Pine Grove Long Term Care Residence
8403 Islington Avenue North Woodbridge ON L4L 1X3

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

NITAL SHETH (500), AMY GEAUVREAU (642), STEPHANIE DONI (681)

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): June 17, 18, 19, 20, 21, 2019.

The following intakes were inspected during this inspection:
Intake logs #012828-18 (CIS #2808-000007-18) related to safe transferring, #010551-18 (CIS #2808-000004-18) related to infection prevention and control, #008578-17 (CIS #2808-000012-17) related to duty to protect, and #001186-19 (CIS #2808-000002-19) related to falls.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nurse Manager (NM), Food Service Manager (FSM), Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aide (DA), Residents and Family Members.

During the course of the inspection, the inspector(s) observed residents’ care areas, reviewed residents’ records and the home’s records.

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

During the course of this inspection, Non-Compliances were issued.

1 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	Légende 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. 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 protect resident #003 from sexual abuse.

For the purposes of the definition of sexual abuse in subsection (2) 79/10, "sexual abuse" means, (a) subject to subsection (3), any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A review of Critical Incident System (CIS) report indicated an alleged sexual abuse by a retirement resident, towards a long-term care home (LTC) resident #003. The resident had no cognitive impairment. Resident #003 reported to the staff that the retirement resident approached them in a common area of the home and conducted themselves inappropriately.

Observations conducted throughout the inspection, indicated the LTC home is connected to a 10 bed retirement residence. The building has a common entrance and reception areas for both facilities (LTC and retirement home). The retirement home has an entrance with a door having mag-lock which goes to the stairs to the basement area. There are two separate secured doors located in the reception-lobby areas with mag-locks to enter into the LTC home and the retirement home.

Interview with resident #003 indicated that they recalled the incident, the retirement resident conducted themselves inappropriately. Resident #003 pushed them away and went to their room. Resident #003 indicated that they were shocked, could not sleep at night, was feeling upset and agitated because of the incident. The resident indicated they felt like they were treated like an animal. The resident indicated that they did not report the incident to their family immediately, because they knew that their family would be busy and did not want to bother them. It was reported four days later to the family and they were asked not to share the information because they felt embarrassed about the incident.

A review of the home's investigation record indicated that the allegation of abuse was unverified.

A review of the home's policy #LTC-CA-WQ-100-05-18, entitled, "Abuse Free Communities- Prevention, Education and Analysis", revised July 2016, indicated that the home has a zero tolerance of abuse policy and it applies to the home's long-term care residents. The home will not tolerate any form of resident abuse as defined in the policy.

The policy indicated that any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member is considered as sexual abuse.

Interview with RN #101 and Nurse Manager #103 indicated resident #003 reported the incident four days later, there was an attempt, and resident #003 pushed them away. Resident #003 had no emotional harm as a result of the incident. Nurse Manager #103 indicated that based on the home's policy, the incident was sexual abuse in nature. RN #101 and Nurse Manager #103 indicated that the incident happened in the common area of the LTC home and retirement residence.

Interview with the Administrator indicated that the incident was investigated, and it was not verified that abuse occurred. It happened in the common area of the home. The administrator acknowledged that the building is shared with retirement home and the same management staff operate both facilities. The common areas such as reception-lobby areas, parking and garden areas can be used by any residents living in either of the facilities who are independently able to go in and out of the building. These common areas are a part of the residents' living experience in retirement and long-term care.

RN #101, Nurse Manager #103, and the administrator indicated that resident #003 was allowed to go out independently as per their plan of care. The incident happened outside of the LTC home, and therefore, the home did not fail to protect the resident from abuse.

The inspector issued this non-compliance based on the fact that, the resident with no cognitive impairment confirmed the inappropriate behaviour from the retirement resident was unwelcomed. The inspector identified that residents using common areas of the home, including a reception-lobby area is a part of their living experience at the LTC home. Therefore, the home is responsible for protecting residents from abuse in other areas of the building which residents may use including public/shared spaces. [s. 19. (1)]

Issued on this 27th day of June, 2019

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

Original report signed by the inspector.