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
Nov 3, 2016	2016_263524_0032	029340-16	Critical Incident System

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

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

Berkshire Care Centre
350 DOUGALL AVENUE WINDSOR ON N9A 4P4

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

INA REYNOLDS (524)

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): October 5, 6, 2016.

This Critical Incident #2541-000030-16 is related to allegations of resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care, two Registered Practical Nurses, two Personal Support Workers and one Program Aide.

The inspector completed interviews, observed resident care areas, reviewed relevant policies, records, and documentation.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
2 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 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 the residents were protected from abuse by anyone.

The definition of sexual abuse, in the Long-Term Care Homes Act (LTCH Act) 2007, under s.2(1)(a)(b) heading "sexual abuse" stated: (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 resident was admitted to the home with a specific diagnosis. Review of clinical records and a critical incident indicated that on a specific date and time a Personal Support Worker (PSW) looked into the resident's room and found the resident standing in front of another resident initiating a specific behaviour. Record review identified that the resident had a history of responsive behaviours. A previous critical incident was submitted whereby staff witnessed the resident initiating the same specific behaviour to another resident.

A review of the progress notes for identified dates revealed the resident engaged in specific behaviours on different occasions; which was witnessed and documented by staff.

An interview was conducted with a Behavioural Supports Ontario (BSO) Registered Practical Nurse (RPN) and a PSW on a specific date and time. It was stated that BSO knew of the resident and the specific interventions that were put into place to prevent further incidents.

Interview with a RPN on specific date, shared that they did not believe that the identified resident was aware of what they were doing when they abused the other resident. The RPN further said that due to dementia the other resident would be unaware of what had occurred; the resident was "in the wrong place, at the wrong time".

An interview was conducted with the Acting Director of Care (ADOC) on a specific date. It was acknowledged that the incident had occurred and it was stated that the resident had a history of this type of behaviour. The ADOC further said that a number of interventions were implement on both residents after the incident. However, when the inspector informed them that a certain intervention was documented in the progress notes on a specific date, it was stated they were unaware of a change and directed staff to resume this specific intervention because "I know" the resident.

The licensee failed to ensure that a resident of the home was protected from abuse when another resident was involved in an abuse incident. [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 the residents are protected from abuse by anyone, to be implemented voluntarily.

WN #2: 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 :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director: Abuse of a resident by anyone.

Review of clinical records and a critical incident indicated that on a specific date and approximate time a Personal Support Worker (PSW) had observed an identified resident initiating a specific behaviour towards another resident.

Review of the Critical Incident System used to report incidents to the Director indicated that the observed incident of resident to resident abuse was not immediately reported to the Director. Further review of progress notes on PointClickCare indicated that the incident was immediately reported to the Acting Director of Care on an identified date.

The Acting Director of Care said they were aware of the incident and started to enter information into the Critical Incident System but did not immediately notify the Director of the alleged abuse and acknowledged they should have notified the Director. [s. 24. (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 person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director: Abuse of a resident by anyone, to be implemented voluntarily.

Issued on this 16th day of November, 2016

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

Original report signed by the inspector.