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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 18, 2017	2017_566669_0021	018723-17	Complaint

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

ANDREA DIMENNA (669)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 21 and 22, 2017.

This complaint was related to abuse and alleged insufficient staffing.

The following critical incident was completed with this inspection: 2541-000032-17/Log #019301-17, related to abuse.

During the course of the inspection, the inspector(s) spoke with five residents, Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Business Manager, Staff Scheduler, two Registered Nurses (RNs), two Registered Practical Nurses (RPNs), and five Personal Support Workers (PSWs).

During the course of the inspection, the Inspector made observations of residents, activities and care. Relevant policies and procedures, staffing schedules, and clinical records and plans of care for identified residents were reviewed.

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

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
1 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 :

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 have occurred, immediately reported the suspicion and the information upon which it was based to the Director: 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.

This inspection was conducted as a result of a Complaint received by the Ministry of Health and Long-Term Care (MOHLTC) on a specified date and a Critical Incident System Report received by the MOHLTC three days following the date of the Complaint, which both reported that an identified resident hit another resident, resulting in injury.

The home’s Abuse and Neglect Policy (RCS P-10), revised July 2, 2015, was reviewed and stated that where a staff member had a reason to believe that a resident suffered harm or was at risk of harm due to abuse, they must immediately report their suspicion and the information upon which it was based, to the Home, and to the Director appointed under the Long-Term Care Homes Act.

A record review showed that on a specified date, a resident was found by a PSW with injuries. Records stated that the identified resident admitted to hitting the co-resident and verbally threatened them. The co-resident's progress notes stated that they received treatment for their injuries. The Critical Incident System Report was first submitted to the

MOHLTC three days following this incident, and the MOHLTC after hours line was not called about this incident.

A PSW was interviewed and recalled walking by the co-resident's room when the PSW noticed that the resident had visible injuries, and reported this to the RPN immediately. The PSW recalled that the identified resident admitted to hitting the co-resident. The PSW clarified that the incident was unwitnessed, and they were the first person on scene.

The RPN was interviewed and recalled being notified of the incident by the PSW, and that the co-resident had visible injuries. The RPN said that the identified resident admitted to hitting the co-resident and had verbally threatened the co-resident. The RPN reported that they called the charge RN and the physician for instruction.

The ADOC was interviewed and stated that they completed the Critical Incident System Report three days following the incident, and acknowledged that the MOHLTC after hours line was not called. The ADOC stated that the MOHLTC after hours line should have been called right away to report the incident, as per the home's protocol.

The DOC acknowledged that the nurse working on the date of the incident did not follow protocol and did not call the MOHLTC after hours line.

The Administrator said that this incident was considered abuse and it was the home's expectation that abuse was reported to the MOHLTC immediately.

The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident occurred, immediately reported the suspicion and the information upon which it was based to the Director.

The severity of this issue was determined to be a level one as there was minimum risk, and the scope was isolated. The home's compliance history was reviewed and this legislation was issued on August 25, 2016, as a Voluntary Plan of Correction (VPC) in a complaint inspection and on October 4, 2016, as a VPC in a critical incident inspection. [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 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: 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, to be implemented voluntarily.

Issued on this 24th day of October, 2017

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

Original report signed by the inspector.