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 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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 24, 2019	2019_563670_0002	014638-17, 021913-17, 028032-17, 028161-17, 002530-18, 003021-18, 004794-18, 005575-18, 005737-18, 006740-18, 008363-18, 016958-18, 018122-18, 022978-18, 023195-18, 023334-18, 024518-18, 024585-18, 026181-18, 026814-18, 029409-18, 032330-18, 032817-18, 033504-18	Critical Incident System

Licensee/Titulaire de permis

Rykka Care Centres LP
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

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

DEBRA CHURCHER (670), CAROLEE MILLINER (144), JULIE DALESSANDRO (739), TERRI DALY (115)

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): January 7, 8, 9, 10, 11, 14, 15, 16, 17, 18 and 21, 2019.

The following intakes were inspected within this inspection:

Log# 018122-18 CIS# 2541-000044-18 related to a fall with injury.
Log# 026181-18 CIS# 2541-000064-18 related to alleged staff to resident abuse.
Log# 021913-17 CIS# 2541-000037-17 related to alleged staff to resident abuse.
Log# 026814-18 CIS# 2541-000067-18 related to alleged staff to resident abuse.
Log# 005575-18 CIS# 2541-000020-18 related to alleged staff to resident abuse.
Log# 028032-17 CIS# 2541-000043-17 related to alleged staff to resident abuse.
Log# 023334-18 CIS# 2541-000053-18 related to alleged resident to resident abuse and responsive behaviors.
Log# 024518-18 CIS# 2541-000058-18 related to alleged resident to resident abuse and responsive behaviors.
Log# 003021-18 CIS# 2541-000011-18 related to alleged resident to resident abuse and responsive behaviors.
Log# 028161-17 CIS# 2541-000041-17 related to alleged resident to resident abuse and responsive behaviors.
Log# 002530-18 CIS# 2541-000007-18 related to alleged resident to resident abuse and responsive behaviors.
Log# 029409-18 CIS# 2541-000074-18 related to alleged resident to resident abuse and responsive behaviors.
Log# 014638-17 CIS# 2541-000029-17 related to alleged resident to resident abuse and responsive behaviors.
Log# 024585-18 CIS# 2541-000057-18 related to alleged resident to resident abuse and responsive behaviors.
Log# 008363-18 CIS# 2541-000026-18 related to alleged resident to resident abuse and responsive behaviors.
Log# 005737-18 CIS# 2541-000019-18 related to alleged resident to resident abuse

and responsive behaviors.
Log# 004794-18 CIS# 2541-000018-18 related to alleged resident to resident abuse and responsive behaviors.
Log# 016958-18 CIS# 2541-000040-18 related to alleged resident to resident abuse and responsive behaviors.
Log# 023195-18 CIS# 2541-000052-18 related to alleged resident to resident abuse and responsive behaviors.
Log# 006740-18 CIS# 2541-000023-18 related to alleged resident to resident abuse and responsive behaviors.
Log# 032330-18 CIS# 2541-000081-18 related to alleged resident to resident abuse and responsive behaviors.
Log# 032817-18 CIS# 2541-000086-18 related to alleged resident to resident abuse and responsive behaviors.
Log# 033504-18 CIS# 2541-000087-18 related to alleged resident to resident abuse and responsive behaviors.
Log# 022978-18 CIS# 2541-000050-18 related to alleged improper care.

During the course of the inspection, the inspector(s) spoke with one Director of Care, one Vice President of Operations, 16 Personal Support Workers, one Behavior Supports Ontario Personal Support Worker, eight Registered Practical Nurses, two Registered Nurses, one Security Guard, one Recreation Director, two Recreation Aides, one Quality Improvement Coordinator and one Behavior Supports Ontario Registered Practical Nurse.

During the course of this inspection Inspectors observed meal services, overall condition of the home, housekeeping and maintenance services, staff to resident interactions and provision of care, reviewed relevant polices and procedures and reviewed relevant clinical records.

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

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

5 WN(s)
5 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 ensure that residents were protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The home called the info line on a specific date and submitted a Critical Incident System (CIS) report on a specific date. The CIS stated that during a review of the homes cameras related to a staff issue it was noted that on a specific date staff member #143 behaved in an inappropriate manner towards resident #016.

Review of the homes investigation documents showed that the previous Executive Director (ED) #136 of the Home had interviewed staff member #126. The documentation showed that staff member #126 informed ED #136 that they had witnessed staff member #143 on at least two occasions behaving inappropriately towards residents.

Review of the homes investigation documents showed that, the previous ED #136 had interviewed staff member #132. The documentation showed that staff member #132 informed ED #136 that they had witnessed staff member #143 behaving inappropriately with residents. Staff member #132 also stated that they could not recall specific dates but had reported to the previous Department Director. When asked if this had happened again recently staff member #132 stated that approximately two weeks prior to the interview they had witnessed staff member #143 again behaving inappropriately with residents. Staff member #132 stated that they had not had a chance to report to the current Department Director.

During an interview on January 16, 2019, with staff member #126 they stated that they had witnessed staff member #143 behaving inappropriately on at least three occasions prior to the interview with the previous ED #136. When asked if they had reported the incidents they stated that they had not and that they were unsure if this was abuse or not.

During a telephone interview on January 17, 2019, with staff member #132 the documentation of the interview conducted by the previous ED #136 was reviewed and staff member #132 stated that the interview was correct and also stated that they had not reported to the current Department Director.

During an interview with the current Department Director #133 they stated that they had become the Department Director in March of 2017. Stated that they had not had any reports from staff regarding concerns with staff member #143 behaving inappropriately towards residents but had on one occasion in 2017 since starting as the Director of the department had to speak with staff member #143 regarding their inappropriate behavior towards residents.

January 18, 2019, Director of Care #102 stated that staff member #143's actions would be considered abuse.

The licensee has failed to ensure that residents were protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. [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 the home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, 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).

Findings/Faits saillants :

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

The home called the info line on a specific date and submitted a Critical Incident System (CIS) report on a specific date. The CIS stated that during a review of the homes cameras related to an staff issue it was noted that on a specific date staff member #143 behaved in an inappropriate manner towards resident #016.

Review of the homes investigation documents showed that the previous Executive Director (ED) #136 of the Home had interviewed staff member #126. The documentation showed that staff member #126 informed ED #136 that they had witnessed staff member #143 on at least two occasions behaving inappropriately towards residents.

Review of the homes investigation documents showed that, the previous ED #136 had interviewed staff member #132. The documentation showed that staff member #132 informed ED #136 that they had witnessed staff member #143 behaving inappropriately with residents. Staff member #132 also stated that they could not recall specific dates but had reported to the previous Department Director. When asked if this had happened again recently staff member #132 stated that approximately two weeks prior to the interview they had witnessed staff member #143 again behaving inappropriately with residents. Staff member #132 stated that they had not had a chance to report to the current Department Director.

During an interview on January 16, 2019, with staff member #126 they stated that they had witnessed staff member #143 behaving inappropriately on at least three occasions prior to the interview with the previous ED #136. When asked if they had reported the incidents they stated that they had not and that they were unsure if this was abuse or not.

During a telephone interview on January 17, 2019, with staff member #132 the documentation of the interview conducted by the previous ED #136 was reviewed and staff member #132 stated that the interview was correct and also stated that they had not reported to the current Department Director.

During an interview with the current Department Director #133 they stated that they had become the Department Director in March of 2017. Stated that they had not had any reports from staff regarding concerns with staff member #143 behaving inappropriately towards residents.

The home's policy titled Abuse and Neglect Policy, last reviewed on February 19, 2018, stated, As set out in the LTCHA, any 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 was based to the Director of Long-Term Care Homes:b) abuse of a Resident by anyone, or neglect of a Resident by the licnesee or staff member that resulted in harm or a risk of harm to the Resident. The Home requires all staff members to also make the above described report to the home.

January 18, 2019, Director of Care #102 stated that staff member #132 and staff member #126 should have reported immediately and did not follow the homes policy.

The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with. [s. 20. (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 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, to be implemented voluntarily.

WN #3: 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 has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director:
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.
3. Unlawful conduct that resulted in harm or risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under the Act.

The home called the info line on a specific date, IL #18995-LO and submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHL-TC) three days after calling the info line. The occurrence date on the CIS was 37 days prior to the call to the info line. The CIS stated that during a review of the homes cameras related to a staff issue it was noted that staff member #143 was observed, on the occurrence date on the CIS, to have behaved inappropriately with a resident.

Review of the home's investigative notes showed that the previous Executive Director (ED) #136 had interviewed and placed staff member #143 on leave, on a specific date which was 16 days prior to the call placed to the info line. ED#136 interviewed staff

member #126 10 days prior to the call to the info line, and was informed that staff member #126 had witnessed staff member #143 have inappropriate interactions with residents. The notes also showed that the previous Executive Director (ED) #136 had interviewed Staff member #132 nine days prior to the call to the info line and was informed that staff member #132 had witnessed staff member #143 have inappropriate interactions with residents.

January 18, 2019, Inspector #670 reviewed the internal investigation notes with the Director of Care (DOC) #102. DOC #102 stated that they were requested by the previous ED #136 to call the info line and stated that they were not sure what date the cameras were reviewed by the previous ED #136 but that it would have been prior to interviewing any staff. DOC #102 acknowledged that if there was suspicion that staff member #143 had behaved inappropriately with a resident after review of the tapes that a report should have been submitted to the MOHL-TC and at a minimum, after the interview with staff member #126, where staff member #126 had shared that they had witnessed inappropriate behavior between staff member #143 and residents, there should have been an immediate report to the MOHL-TC.

1. The licensee has failed 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:
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.
3. Unlawful conduct that resulted in harm or risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under the Act.[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 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. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 58. Every licensee of a long-term care home shall ensure that when transferring and positioning residents, staff shall use devices and techniques that maintain or improve, wherever possible, residents' weight bearing capability, endurance and range of motion. O. Reg. 79/10, s. 58.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The home's Mechanical Lifts policy last reviewed November 30, 2018, includes the following directive:
"For residents who required sit to stand lift (based on completed assessment in Point Click Care (PCC)), two staff assistance will be provided."

On a specific date during the inspection, the inspector left the elevator and observed Personal Support Worker (PSW) #100 pushing resident #001 using a medical device.

PSW #100 told the inspector that resident #001 required two staff for a specific Activity of

Daily Living (ADL) and required the use of specific medical equipment for another ADL, that the resident could participate in another specific ADL with the assist of one PSW and that they had just performed this specific ADL with the resident by themselves.

PSW #100 and the inspector together reviewed the current care plan for resident #001.

The current care plan for resident #001 included that resident #001 "required extensive assistance for a specific ADL from two staff with the use of specific medical equipment."

PSW #100 also said that two PSW's were on their break at the time the resident had a specific ADL need and that the Registered Practical Nurse (RPN) could not assist with the transfer as they (RPN) were giving medications.

PSW #100 confirmed that they did not ask the RPN for assistance with the specific ADL need for resident #001.

RPN #101 confirmed that PSW #100 did not request their assistance to assist with the specific ADL for resident #001 and that they would have provided the assistance if asked.

DOC #102 told the inspector that it was their expectation that when staff were off the nursing unit for their breaks, the remaining staff on the unit would request assistance from the RPN as needed to assist with specific ADL's.

On a specific date during the inspection, resident #001 was observed in a specific position using a medical device.

PSW #100 said that the resident had the ability to use the medical device in a specific manner and did not use a portion of the medical device.

The inspector observed the specific limbs of resident #001 in an inappropriate position.

On a specific date during the inspection, RPN #105 and the inspector located two portions of the medical device in resident #001's clothing wardrobe, that PSW #100 had previously stated the resident did not use.

RPN #105 and PSW #107 told the inspector that resident #001 used these portions of the medical device daily and that the personnel that completed the resident's morning care is responsible for ensuring the portions of the medical device were applied.

The current care plan for resident #001 includes that the resident required a medical device for assistance with a specific ADL. The current care plan does not include use of portion of the medical device that the resident used daily during morning care.

DOC #102 shared with the inspector that resident #001 usually had the specific portions of the medical device in place.

The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents. [s. 58.]

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 when transferring and positioning residents, staff shall use devices and techniques that maintain or improve, wherever possible, residents' weight bearing capability, endurance and range of motion, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's written record is kept up to date at all times.

During the inspection, a Critical Incident System report (CIS) was reviewed related to abuse/neglect.

During the inspection, the clinical records for residents #025 and resident #026 were reviewed.

The clinical record for resident #025 did not include documentation related to a witnessed incident where resident #026 displayed responsive behaviors towards resident #025.

DOC #102 confirmed with the inspector that RPN #119 should have documented the incident in the clinical record for resident #025 and in the risk management section of the Point Click Care (PCC) electronic program.

During the inspection an additional CIS report was reviewed related to abuse/neglect.

During the inspection, the clinical records for residents #026 and #029 were reviewed.

The clinical record for resident #029 did not include documentation related to a witnessed incident where resident #026 displayed responsive behaviors towards resident #029.

DOC #102 confirmed with the inspector that RPN #120 should have documented the incident in the clinical record for resident #029 and in the risk management section of the POC electronic program.

The licensee has failed to ensure that the resident's written record is kept up to date at all times. [s. 231. (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, (a) a written record is created and maintained for each resident of the home; and (b) the resident's written record is kept up to date at all times, to be implemented voluntarily.

Issued on this 7th day of February, 2019

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

Original report signed by the inspector.