Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jul 8, 2020	2020_767643_0010	002853-20	Critical Incident System

Licensee/Titulaire de permis

Chartwell Master Care LP
7070 Derrycrest Drive MISSISSAUGA ON L5W 0G5

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

Chartwell White Eagle Long Term Care Residence
138 Dowling Avenue TORONTO ON M6K 3A6

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

ADAM DICKEY (643)

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 22, 23, 25, 29, 30 and July 2, 2020.

The following Critical Incident System (CIS) intake was inspected during this inspection:
Log #002853-20; CIS report #2583-000001-20 - related to a resident altercation.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RN) and Personal Support Workers (PSW).

During the course of the inspection the Inspector conducted review of resident health records, the home's internal investigation notes and relevant policies and procedures.

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.
- **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. 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 a person who had reasonable grounds to suspect abuse of a resident had occurred immediately reported the suspicion and the information upon which it was based to the Director.

On August 31, 2018, the Director informed licensees and Administrators via a memorandum titled Clarification of Mandatory and Critical Incident Reporting Requirements of the process for submitting reports to the Director under s. 24 (1) of LTCHA, 2007. The memorandum directed licensees that when a report to the Director is required under s. 24 (1) outside of the hours of 0830 – 1630, that the information should first be reported via the ServiceOntario after-hours reporting line followed by submission of the Critical Incident System (CIS) report the following business day.

A CIS report was submitted by the home on an identified date, for an incident which occurred four days earlier, involving residents #001 and #002 in which abuse was suspected. The incident was initially reported via the ServiceOntario after-hours reporting line on the date of the incident, by RN #102. The CIS report regarding the incident was submitted three business days following the date of the incident.

In an interview, DOC #100 indicated that they had become aware of the incident occurring on the above identified date, via a report from RN #102. The DOC indicated that they had been aware of the memorandum from the Director above and that when there were reasonable grounds to suspect abuse of a resident by anyone may have occurred, the CIS report was required to be submitted the next business day. The DOC indicated that they may have been off the two days prior to submitting the CIS report, and acknowledged that the report was not submitted on the business day following the incident. [s. 24. (1)]

Issued on this 14th day of July, 2020

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

Original report signed by the inspector.