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 # / Registre no	Type of Inspection / Genre d’inspection
Sep 19, 2016	2016_360111_0016	020368-16, 0200006-16	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

BALLYCLIFFE LODGE NURSING HOME
70 STATION STREET AJAX ON L1S 1R9

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

LYNDA BROWN (111)

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): August 22 & 23, 2016

Two critical incident reports were inspected concurrently during this inspection:
-Log # 020368-16 related to an anonymous complaint regarding a private care worker. No areas of non-compliance were identified related to this log.
-Log # 020006-16 related to allegation of staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Practical Nurse (RPN), Personal Support Worker (PSW) and a resident.

During the course of the inspection, the inspector reviewed the home's investigation, observed the resident, reviewed a resident health record, reviewed an employee record and reviewed the home's policies on complaints, and Prevention of Abuse and Neglect.

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

During the course of this inspection, Non-Compliances were issued.
2 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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the results of the abuse or neglect investigation were reported to the Director and every action taken.

Re: Critical Incident Log # 0200006-16 for resident #005:

A critical incident report was received by the Director on a specified date for an allegation of staff to resident abuse that occurred. The allegation was reported by the resident to the home the day after the incident occurred. Resident #005 reported that on a specified date and time, PSW #112 had been emotionally and physically abusive towards the resident during care. The CIR was amended the following day and indicated "DOC to update when investigation was completed". There were no further amendments to the report.

Interview with the DOC and review of the home’s investigation indicated the investigation was completed the day after the allegation was made and identified actions that were taken to prevent recurrence.

Review of the health care record for resident #005 indicated specific actions were taken following the investigation. This information and any other post investigation information were not provided to the Director.

Therefore, the report to the Director did not indicate the results of the investigation and the actions to be taken by the home to prevent a recurrence.

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 any witnessed, suspected or alleged incident of staff to resident abuse, and that is reported to the Director, indicates the results of the investigation upon completion, or within 21 days of the incident occurring, and that appropriate actions are taken to every such incident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the report to the Director included the following description of the individuals involved in the incident:
(ii) names of any staff members or other persons who were present at or discovered the incident, and
(iii) names of staff members who responded or are responding to the incident.

Re: Critical Incident Log # 0200006-16 for resident #005:

A critical incident report was received by the Director on a specified date for an allegation of staff to resident abuse that occurred the day before. The CIR indicated RPN #100 had reported the allegation but did not indicate any other staff that were present at or discovered the incident.

Interview with the DOC indicated the allegation of staff to resident abuse towards resident #005 was reported to her on a specified date and time by RPN #100. The DOC indicated RPN #101, PSW #102, and PSW #103 worked when the alleged incident occurred and confirmed the CIR was not amended to include all the staff who were present or at least discovered the incident.

Issued on this 19th day of September, 2016

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

Original report signed by the inspector.