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 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
Jun 28, 2017	2017_603194_0019	010240-17	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

Chartwell Ballycliffe Long Term Care Residence
70 STATION STREET AJAX ON L1S 1R9

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

CHANTAL LAFRENIERE (194)

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): May 29, 30, 31 and June 1, 2017

Log # 010240-17 related to allegations of staff to resident physical abuse

During the course of the inspection, the inspector(s) spoke with Administrator, Registered Nurse (RN), Food and Nutrition Manager (FNM), Personal Support Workers (PSW) and Resident

Reviewed the licensee's internal abuse investigation, relevant policies and orientation/educational records of identified staff

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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. 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. Log # 010240-17 involving resident #001

The licensee has failed to ensure that the abuse policy LTC-CA-WQ-100-05-18 is complied with.

Review of the licensee's "abuse allegations and follow up" LTC-CA-WQ-100-05-02 dated July 2016 indicated that;

-Abuse reporting is immediate and mandatory: All employees are required to, as a component of Chartwell's internal reporting structure to ensure safety for all, report immediately to their respective supervisor/person in charge of the building when:
-an abuse is witnessed and /or
-an abuse is suspected an/or
-at any time information or knowledge of an allegation of abuse is received or learned from any person.

-Each incident of abuse is to be investigated thoroughly including documentation in accordance with the Chartwell investigation policy.

Procedures:
Allegation of abuse immediate Action
-When a staff member receives a report of abuse or observes anyone (another staff member, volunteer, family member, visitor or residents) abusing a resident in any manner, staff will:
-immediately report the allegations to the ADM/DOC or building Supervisor following the internal reporting system for incident management.

Notification and reporting requirements
-Abuse reporting is immediate and mandatory. IF there is any doubt or question as to whether or not the incident is to be reported to regulatory bodies always make the report. The report is to be amended and updated as more information becomes available during the investigation.
-The Admin/DOC or designate must be notified

The Administrator or designate is responsible to ensure that all documentation that may be required or requested by a regulating/licensing authority is completed in the manner prescribed by the regulatory body or licensing authority.

The supervisor/Designate is responsible for:

-ensuring all facts related to a reported allegation are documented in the resident health chart
-ensuring all physical assessment/examinations are recorded with clear descriptions and details. All entries are to be signed, dated with the time of documentation or indicate that the resident was transported to a medical facility for assessment. Assessment information collected at the medical facility will be retained by the medical facility
-all witness statements are completed prior to staff leaving at the end of their shift and that they are signed and dated.
-completing a resident incident report
-updating the administrator with the finding of the investigation.

"Appendix B" attached to abuse policy directs;
Who reports: Any person receiving information or witnessing an alleged abuse is to report.

A Critical Incident Report involving resident #001 for allegations of staff to resident physical abuse was submitted to the Director in May 2017.

Review of the internal investigation completed by the home identified that while PSW #102 and #103 provided care, resident #001complained of being hurt and was going to report the staff member. The licensee's investigation indicated that both PSW #102 and #103 denied the allegations . PSW #102 declined to be interviewed by inspector #194. PSW #103 indicated during interview with inspector #194 that the allegation of abuse took place at the beginning of the shift. PSW #103 indicated being aware that resident #001 was upset with PSW #102 but did not feel that the care provided to resident #001 by PSW# 102 could have caused any injury. PSW #103 indicated during the interview that PSW #102 had been instructed to report the incident immediately to the Charge Nurse #105. PSW #103 indicated that resident #001 was provided care again at the end of the shift. Resident #001 continued to be upset with PSW #102, so PSW #103 provided the majority of the care with no voiced concerns from resident #001. The incident was not reported until the end of shift by both PSW's to RN #105. RN# 105 indicated to inspector that since both PSW's denied the allegations, RPN #105 did not feel that there was reasonable grounds to suspect the abuse had occurred. The Director was not immediately notified of the allegations reported by PSW #102 and #103 for complaint of resident #001 being hurt by the staff during care.

The licensee failed to comply with it's abuse policy when PSW #102 and #103 did not immediately report the allegations hurting resident #001 during care. RN #105 did not

immediately report to Director , immediately inform Administrator, investigate or document the allegations of staff grabbing resident #001 when it was reported by PSW #102 and PSW #103 at the end of the shift. [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 ensuring that it's abuse policy is complied with, to be implemented voluntarily.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated:
(i) Abuse of a resident by anyone.

Log # 010240-17 involving resident #001

A Critical Incident Report involving resident #001 for allegations of staff to resident physical abuse was reported to the Director in May 2017.

Review of the internal investigation completed by the home identified that while PSW #102 and #103 provided care, resident #001complained of being hurt and was going to report the staff member. The incident was not reported until the end of shift by both PSW's to RN #105. RN #105 indicated during interview that an attempt to interview resident #001 was made when the incident was reported but the resident was asleep. RN# 105 indicated to inspector that an investigation into the allegations reported by PSW's was not immediately initiated. [s. 23. (1) (a)]

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 ensuring that all incident of abuse are immediately investigated, 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.
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.

Log # 010240-17 involving resident #001

A Critical Incident Report involving resident #001 for allegations of staff to resident physical abuse.

Review of the internal investigation completed by the home identified that while PSW #102 and #103 provided care, resident #001complained of being hurt and was going to report the staff member. The incident was not reported until the end of shift by both PSW's to RN #105. RN# 105 indicated to inspector that since both PSW's denied the allegations, RPN #105 did not feel that there was reasonable grounds to suspect the abuse had occurred. The Director was not immediately notified of the allegations reported by PSW #102 and #103 for complaint of resident #001 being grabbed by the staff during care. [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 ensuring that all incidents of abuse are immediately reported, to be implemented voluntarily.

Issued on this 28th day of June, 2017

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

Original report signed by the inspector.