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
Jul 5, 2017	2017_538144_0031	009228-16, 009242-16, 009533-16, 012433-16, 019505-16, 023061-16, 026672-16, 029240-16, 029586-16, 029834-16, 032142-16, 032305-16, 032812-16, 033935-16, 034419-16, 000055-17, 000352-17, 001491-17, 003736-17, 004178-17, 004181-17, 004670-17, 005708-17, 006943-17, 008102-17, 008693-17, 009627-17, 009807-17	Critical Incident System

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

BANWELL GARDENS
3000 BANWELL ROAD P. O. BOX 3246 TECUMSEH ON N8N 2M4

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

CAROLEE MILLINER (144), ALICIA MARLATT (590), ALISON FALKINGHAM (518), RHONDA KUKOLY (213)

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 26, 27, 28, 29, 30, 2017.

Complaint inspection 2017-539144-0030 was completed concurrently while in the home completing this critical incident inspection.

The following critical incidents were inspected as part of this critical incident inspection:

Related to responsive behaviours:
Log #009242-16, CI M2263-000009-16

Related to falls:
Log #019505-16, CI M2263-000027-16
Log #29240-16, CI M2263-000048-16

Related to neglect:
Log #023061-16, CI M2263-000036-16
Log #029586-16, CI M2263-000050-16

Related to alleged staff to resident abuse:
Log #009627-17, CI M2263-000034-17
Log #032812-16, CI M2263-000061-16
Log #003736-17, CI M2263-000015-17
Log #032305-16, CI M2263-000059-16
Log #009228-16, CI M2263-000011-16
Log #008102-17, CI M2263-000030-17

Related to alleged resident to resident abuse:
Log #032142-16, CI M2263-000058-16
Log #034419-16, CI M2263-000067-16
Log #000055-17, CI M2263-000009-17
Log #004670-17, CI M2262- 000018-17

Log #033935-16, CI M2263-000066-16
Log #001491-17, CI M2263-000012-17
Log #004181-17, CI M2263-000017-17
Log #004178-17, CI M2263-000016-17
Log #005708-17, CI M2263-000025-17
Log #006943-17, CI M2263-000026-17
Log #008693-17, CI M2263-000031-17
Log #009807-17, CI M2263-000035-17
Log #026672-16, CI M2263-000042-16
Log #029834-16, CI M2263-000054-16
Log #012433-16, CI M2263-000020-16
Log #009533-16, CI M2263-000013-16
Log #00352-17, CI M2263-000001-17

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), the Clinical Coordinator, Quality Improvement Manager, Registered Dietitian (RD), Food Service Manager, the Physiotherapist, three Registered Nurses (RN), six Registered Practical Nurses (RPN), eleven Personal Support Workers (PSW), one Health Care Aide, one Restorative Care Aide, one Housekeeping Aide and one Registered Practical Nursing Student.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Falls Prevention
Medication
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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 a 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 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.

The home's policy related to Abuse and Neglect, RCS P-10 last revised July 2, 2015, stated:
Procedure A.General
5. Abuse in relation to a resident means (a) physical abuse (b) sexual abuse (c) emotional abuse (d)verbal abuse (e) financial abuse

On one identified date, one identified staff member observed an incident of staff to resident abuse by a PSW. The identified staff member said the incident with the PSW was also witnessed by two other PSW's.

Two days later, the identified staff member sent an email to the DOC which stated that the identified staff member had witnessed abuse and described the situation. An internal investigation was initiated by the DOC and one PSW received discipline and re education related to resident abuse. The DOC submitted a Critical Incident System (CI) report to

the Ministry of Health and Long-Term Care related to the incident.

Two RN's and one PSW stated during an interview with the Inspector that a certain action constituted abuse and needs to be reported immediately to the nurse in charge at the time of the incident or the manager on call.

The Administrator stated that this incident of abuse should have been immediately reported to the RN in charge and the on call manager.

The licensee has failed to ensure that a 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 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.

The severity of this issued was determined to be level one as there was minimal harm or potential for actual harm. The scope was isolated during the course of the inspection. The home does not have a history of non-compliance with this subsection of the legislation. [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 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 is based to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident or the resident's substitute decision maker were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

The home immediately reported an alleged incident of staff to resident abuse involving one resident to the Director by telephone on a specified date.

The report of alleged abuse from the staff was also immediately reported to the resident's substitute decision maker (SDM).

The CI report that was last submitted and/or changed related to this incident stated the ADOC informed the family that the ADOC would be investigating the resident's complaint and report back to them.

A record review of progress notes in Point Click Care (PCC) for this resident and the home's internal investigation records was completed. There was no documentation found related to the resident or SDM being notified of the outcome of the investigation.

Assistant Director of Care (ADOC) during an interview said that the incident of abuse was not substantiated, the resident was not harmed, and that the investigation was complete.

After review of the CI report to the Director and progress notes for this resident in PCC with Inspector #213, the ADOC said that the resident and/or SDM had not been notified of the outcome of the investigation. The ADOC notified the SDM of the results of the investigation after the interview with the Inspector.

The licensee has failed to ensure that one resident or the resident's SDM were notified of the results of the investigation of alleged staff to resident verbal abuse were immediately upon the completion.

The severity of this non-compliance was determined to be level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home does not have a history of non-compliance with this subsection of the regulation. [s. 97. (2)]

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 resident or the resident's substitute decision maker were notified of the results of the alleged abuse or neglect investigation immediately upon the completion, to be implemented voluntarily.

WN #3: 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 that the results of the abuse or neglect investigation were reported to the Director.

The home immediately reported an alleged incident of staff to resident abuse involving one resident to the Director by telephone on a specified date.

The details of the CI report of abuse were also reported to the Director in a CI report #2263-000034-17. The report that was last submitted and/or changed stated an investigation was launched and described the staff that were interviewed and the statements of staff. The report also stated "investigation is ongoing".

The ADOC during an interview said that the incident of abuse was not substantiated, the resident was not harmed, and that the investigation was complete.

After review of the CI report to the Director with Inspector #213, the ADOC said that the report had not been amended with the outcome or results of the investigation.The ADOC updated the CI report to the Director with the results of the investigation after the interview with the Inspector.

The licensee failed to report the results of the investigation of staff to resident abuse to the Director related to one resident.

The severity of this issue was determined to be level one with minimum harm. The scope was isolated during the course of the inspection. The home does not have a history of non-compliance with this subsection of the legislation. [s. 23. (2)]

Issued on this 6th day of July, 2017

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

Original report signed by the inspector.