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 # / No de registre	Type of Inspection / Genre d'inspection
Nov 24, 2017	2017_591623_0021	014834-17	Resident Quality Inspection

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

Chartwelll Bon Air Long Term Care Residence
131 Laidlaw Street South Cannington ON L0E 1E0

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

SARAH GILLIS (623), JULIET MANDERSON-GRAY (607), SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): November 9, 10, 14, 15, 16, and 17, 2017.

The following were inspected concurrently during the RQI inspection:
Log #033885-16 - Complaint related to resident charges.
Log #034627-16 - Complaint related to resident responsive behaviours.
Log #000109-17 - Complaint related to resident care.
Log #015317-17 - Critical Incident related to fall resulting in a significant change in condition.
Log #033984-16 - Critical incident related to allegation of staff to resident physical abuse.
Log #035027-16 - Critical incident related to allegation of staff to resident verbal abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Dietitian, Physiotherapist (PT), Business Manager, Food Services manger, Maintenance, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aids (DA), Restorative Care Aids (RCA), resident's and family members.

In addition, the Inspectors toured the home, observed staff to resident and resident to resident interactions, resident social programs, resident meal service, medication administration and infection control practices. The Inspectors reviewed clinical health records, staff education records, medication incidents, Medication Management meeting minutes, Resident Council meeting minutes, family communication meeting minutes, the licensee's investigation documentation, and the licensee's related policies: Skin Care Program, Continence Care, Resident Abuse, Critical Incident Reporting, Medication Incidents.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Resident Charges
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **6 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. The licensee has failed to ensure that the written policy that promotes zero tolerance

of abuse and neglect of residents is complied with.

Related to log #033984-16 and log #035027-16

Review of the policy #: LTC-CA-ON-100-05-04
Critical Incident Reporting (revision date January 2016)

Procedures: (page 4 of 6)

3. For critical incidents involving residents, Registered Staff will:
a) Assess the resident and determine if emergency services need to be called.
b) Notify the Director of Care or designate of the situation - this may be the first action depending on the type of critical incident.
c) Complete the resident incident report in the Risk Management module of Point Click Care
d) Document the specific details and facts of the incident in progress notes in the resident chart.

Review of the Critical Incident Report (CIR) - staff to resident alleged physical abuse towards resident #024 and #016, and CIR - staff to resident alleged verbal abuse towards resident #025 was completed. Both CIR's indicated that the alleged incidents occurred on a specified date and were reported to the Director three days later.

Review of the licensee's internal records indicated that for resident's #024, #025 and #026 there was no documentation in the clinical records including a resident incident report in the Risk Management module of Point Click Care and documentation of the specific details and facts of the alleged incidents in the progress notes in the resident's chart.

During an interview, RN #100 indicated that when a critical incident, including an incident of alleged physical or verbal abuse occurs he/she does not document the details of the incident in the resident's chart in Point Click Care and does not complete a risk management report in Point Click Care. RN #100 indicated that he/she was not aware of the documentation required as per the licensee's policy #:LTC-CA-ON-100-05-04 - Critical Incident Reporting.

During an interview, the Director of Care (DOC) indicated that it is the expectation all staff will follow the policy #:LTC-CA-ON-100-05-04 - Critical Incident Reporting, when

any alleged, witnessed or suspected abuse occurs, which includes documenting a resident incident report in the Risk Management module of Point Click Care and documentation of the specific details and facts of the incident in progress notes in the resident's chart. The DOC indicated that the incidents of alleged verbal and physical abuse towards residents #024, #025 and #026 were not documented in the clinical records in PCC.

The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents which includes Critical Incident Reporting, 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 ensuring that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: 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.

Related to Log# 033984-16

A critical incident report (CIR) was submitted to the Director on a specified date, for an incident of alleged staff to resident verbal abuse that occurred three days prior. The CIR indicated that a written report was submitted to the Director of Care by a PSW alleging that another staff member yelled at a resident for soiling his/her incontinence product when providing care.

Review of the licensee's internal records identified that on a specified date, Acting DOC #113 placed PSW #108 on a leave of absence pending an investigation of allegation of verbal abuse towards resident #025 that had occurred on two days prior. A report to the Director was not made until one day after the licensee initiated the internal investigation.

Acting DOC #113 was not available for an interview during the inspection as he/she is no longer employed by the licensee.

The licensee failed to immediately report the allegation of verbal abuse towards resident #025 by PSW #108. [s. 24. (1)]

2. 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.

Related to Log# 035027-16

A critical incident report (CIR) was submitted to the Director on a specified date, for an incident of alleged staff to resident physical abuse that occurred three days prior. The

CIR indicated that a written report was submitted to the Director of Care by a PSW alleging that another staff member was rough when turning resident #024 and #026 while they were in bed.

Review of the licensee's internal records identified that on a specified date, Acting DOC #113 placed PSW #108 on a leave of absence pending an investigation of allegation of physical abuse towards resident #024 and #026, that had occurred two days prior. A report to the Director was not made until one day after the licensee initiated the internal investigation.

Acting DOC #113 was not available for an interview during the inspection as he/she is no longer employed by the licensee.

The licensee failed to immediately report the allegation of physical abuse towards resident #024 and #026 by PSW #108. [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 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 related to abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 91. Resident charges

Specifically failed to comply with the following:

s. 91. (1) A licensee shall not charge a resident for anything, except in accordance with the following:
1. For basic accommodation, a resident shall not be charged more than the amount provided for in the regulations for the accommodation provided. 2007, c. 8, s. 91 (1).
2. For preferred accommodation, a resident shall not be charged more than can be charged for basic accommodation in accordance with paragraph 1 unless the preferred accommodation was provided under an agreement, in which case the resident shall not be charged more than the amount provided for in the regulations for the accommodation provided. 2007, c. 8, s. 91 (1).
3. For anything other than accommodation, a resident shall be charged only if it was provided under an agreement and shall not be charged more than the amount provided for in the regulations, or, if no amount is provided for, more than a reasonable amount. 2007, c. 8, s. 91 (1).
4. Despite paragraph 3, a resident shall not be charged for anything that the regulations provide is not to be charged for. 2007, c. 8, s. 91 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was not charged for anything except with in accordance with the following:

For anything other than accommodation, a resident shall be charged only if it was provided under an agreement and shall not be charged more than the amount provided for in the regulations, or, if no amount is provided for, more than a reasonable amount. 4. Despite paragraph 3, a resident shall not be charged for anything that the regulations provide is not to be charged for Under O.Reg. 79/10, s. 245, Non-allowable resident charges, the following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. Except in accordance goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a Local Health Integration Network.

Under Long Term Care-Service Accountability Agreement (L-SAA) Policy: LTCH

Required Goods, Equipment, Supplies and Services, Date: 2010-07-01 indicated under section 2.1.12 Other Supplies and Equipment:

The licensee must provide the following goods, equipment, supplies and services to long-term care (LTC) home residents at no charge, other than the accommodation charge payable under the Long-Term Care Homes Act, 2007 (LTCHA), using the funding the licensee receives from the Local Health Integration Network under the Local Health System Integration Act, 2006 (LHSIA) or the Minister under the LTCHA or accommodation charges received under the LTCHA. The list of the goods, equipment, supplies and services the licensee must ensure is provided to residents, where not covered under another government program, is non-exhaustive and does not include a complete list of the goods, equipment, supplies and services the licensee must ensure is provided to residents to meet the requirements under O. Reg. 79/10. The classification of an expenditure into a particular funding envelope is determined in accordance with the Ministry's policy for classifying eligible expenditures and is not reflected in the order or organization of the following list:

2.1.12 Other Supplies and Equipment-Other supplies and equipment including but not limited to:
b. Lift systems, lift scales and transfer supplies and equipment to ensure safe lifting and transferring of residents

Related to Complaint Log #033885-16

A complaint was received by the Director indicating that resident #023 was charged for two transfer poles.

During an interview with staff #116, Restorative Care Aide, indicated to Inspector #570 that currently nine residents use transfer poles at the home. The transfer poles are usually installed at the bed side and at the toilet to assist residents from bed to chair or on and off the toilet. Staff #116 further indicated that residents were billed for transfer poles by the vendors who supplied them until directed by the current Administrator in June 2017, that residents should not be charged for transfer poles and that the cost should be covered by the home.

During an interview, the Administrator indicated to Inspector #570 that she started her role as Administrator seven months ago. The Administrator further inducted that residents were not charged for transfer poles after an inquiry by Inspector #570 on a

specified date, regarding the compliant by the SDM of resident #023 being charged for the transfer poles. The Administrator further indicated that residents currently using transfer poles that were paid for by the resident, were asked if they want to be reimbursed for the cost including resident #023 who was discharged to another LTC home on a specified date. The Administrator indicated prior to assuming her role, residents were billed for transfer poles by the vendor as that was the practice in the home.

On a specified date, the Administrator provided the inspector with documentation that SDMs of residents #002, #009, #032, and #033 were contacted for reimbursement of the cost of the transfer poles on two specified dates. The Administrator indicated that residents #002, #009, #032, and #033 had not been reimbursed for the cost of the transfer poles because they had not submitted a receipt to the licensee. The Administrator further indicated that on a specified date, she contacted the vendors who supplied the transfer poles and found out the cost of the transfer poles and requested a check for refund from corporate office to be issued for the residents or their SDMs.

The licensee failed to provide to residents, transfer supplies and equipment to ensure safe lifting and transferring of residents, using funding received from the local health integration network and the Ministry, in accordance with paragraph 4 of subsection 91(1) of the LTCHA, 2007 and O. Reg. 79/10, s. 245. [s. 91. (1) 4.]

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 a resident is not charged for any goods or services that the licensee is required to provide for residents under any agreement between the licensee and the Ministry of Health and Long-term Care or between the licensee and a Local Health Integration Network, to be implemented voluntarily.

WN #4: 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 that the report to the Director included the following description of the individuals involved in the incident:
(i) names of all residents involved in the incident,
(ii) names of any staff members or others who were present at of discovered the incident,

Related to Log #033984-16

A critical incident report (CIR) was submitted to the Director on a specified date, for an incident of alleged staff to resident verbal abuse that occurred three days prior. The CIR indicated that a written report was submitted to the Director of Care by a PSW alleging that another staff member yelled at a resident for soiling his/her incontinence product when providing care.

Review of the CIR indicated that resident #025 who was the recipient of the alleged verbal abuse is not identified on the report.

Review of the CIR indicated that PSW #108 who was the staff member that allegedly verbally abused resident #025 is not identified on the report.

The Acting Director of Care #113 who completed the CIR was not available for an interview during the inspection as she is no longer employed by the licensee.

During an interview, the DOC indicated that the expectation of the licensee is that the Critical Incident Report would identify the names of any residents and staff that were involved in the alleged incident of abuse.

The licensee failed to ensure that the report to the Director included the names of all residents involved in the incident and the names of any staff members or persons who were present at or discovered the incident of alleged verbal abuse towards resident #025. [s. 104. (1) 2.]

2. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident:
(ii) names of any staff members or others who were present at of discovered the incident,

Related to Log #035027-16

A critical incident report (CIR) was submitted to the Director on a specified date, for an incident of alleged staff to resident physical abuse that occurred three days prior. The CIR indicated that a written report was submitted to the Acting Director of Care (DOC) #113 by a PSW alleging that another staff member was rough when turning resident #024 and #026, in bed to provide care.

Review of the CIR indicated that PSW #108 who was the staff member that allegedly physically abused resident's #024 and #026 was not identified on the report.

The Acting Director of Care #113 who completed the CIR was not available for an interview during the inspection as she is no longer employed by the licensee.

During an interview, the DOC indicated that the expectation of the licensee is that the Critical Incident Report would identify the names of any staff that were involved in the alleged incident of abuse.

The licensee failed to ensure that the report to the Director included the names of any staff members or persons who were present at or discovered the incident of alleged physical abuse towards resident's #024 and #026. [s. 104. (1) 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 ensuring that the report to the Director includes the names of all residents involved in the incident and the names of any staff members or others who were present at the discovery of the incident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Related to resident #030 and #031:

A review of residents #031 Medication Administration Record for a specified month, indicated the resident was receiving four specific medications at 2100 hours.

A review of a Medication Incident Report Form on a specific date, indicated that the identified medications for resident #031 were found in the medication cart for the resident on morning of a specified date and was signed for in the MAR as being given the evening prior.

The RN involved in the medication incident was not available for an interview nor was there documentation of who discovered the incident.

A review of residents #030 Medication Administration Record for a specified month,

indicated the resident was receiving 11 specific medications at 0700, 0800 and 1200 hours.

A review of a Medication Incident Report Form on a specific date, indicated that the identified medications for resident #030 were found in the medication cart for the resident that same evening, and were signed for as being given by the RPN working on that specified date.

During an interview by Inspector #607, RN #115 indicated that resident the Registered Practical Nurse who was working on the evening shift, would have brought the above medication error for resident #030 to his/her attention.

The RPN involved who discovered the incident was not available for an interview.

During an interview, by Inspector #607, the DOC indicated being aware of the above identified medication incidents and indicated the medications were not administered to resident #030 and #031 as prescribed.

The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber, specifically related to resident #031 and #030 did not received medications that were prescribed to them on two specified dates respectively. [s. 131. (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 ensuring that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident is documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

A review of residents #030 Medication Administration Record for a specified month, indicated the resident was receiving 11 specific medications at 0700, 0800 and 1200 hours.

A review of a Medication Incident Report Form on a specific date, indicated that the identified medications for resident #030 medications were found in the medication cart for the resident on evening shift that same day, and were signed by RN #115 as given.

During an interview, by Inspector #607, RN #115 indicated that the Registered Practical Nurse who was working the evening shift on the identified date, would have brought the above medication error for resident #030 to RN #115's attention and indicated that he/she would have asked the RPN to complete an assessment of the resident which would have included a health assessment and a pain assessment. RN #115 further indicated that a documentation of the resident's assessment would have been included in the resident's progress notes.

A review of the progress notes for resident #030 failed to identify documented evidence that immediate action was taken to assess and maintain the resident's health, or an assessment of the resident's pain or glucose levels.

During an interview, the DOC indicated that the expectation is that when a resident misses his/her medications that an assessment be completed of the resident. [s. 135. (1)]

2. Related to resident #031:

A review of resident #031's Medication Administration Record for a specific month, indicated the resident was receiving four specific medications at 2100 hours.

A review of a Medication Incident Report Form on a specific date, indicated that the identified medications for resident #031 were found in the medication cart for the resident on the following evening, the package was dated the day prior, and was signed by RN #115 as administered.

During an interview, by Inspector #607, RN #115 indicated that resident the Registered Practical Nurse who was working on the evening of a specific date, would have brought the above medication error for resident #031 to his/her attention and indicated that RN #115 would have asked the RPN to complete an assessment of the resident which would have included a physical assessment and a pain assessment. RN #115 further indicated that documentation of the resident’s assessment would have been included in the resident’s progress notes.

A review of the progress notes for resident #031 failed to identify documented evidence that immediate action was taken to assess and maintain the resident’s health, or an assessment of the resident’s pain.

During an interview, the DOC indicated that the expectation is that when a resident misses his/her medications that an assessment be completed of the residents.

The licensee failed to ensure that every medication incident involving a resident is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, specifically related to not assessing resident #030 and #031 when the residents missed their medications. [s. 135. (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 every medication incident involving a resident is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, to be implemented voluntarily.

WN #7: 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.

Related to Log#033984-16

A critical incident report (CIR) was submitted to the Director on a specified date, for an incident of alleged staff to resident verbal abuse that occurred three days prior. The CIR indicated that a written report was submitted to the Director of Care by a PSW alleging that another staff member yelled at a resident for soiling his/her incontinence product when the PSW was providing care.

Resident #025 was cognitively impaired and no longer resides in the home.

Review of the CIR, indicated that the report was initially submitted on a specified date and an amendment was completed the following day, to update the description of the incident with more detail and also identifying that the investigation was ongoing. There were no further amendments to include the outcome of the licensee's investigation of the allegation of verbal abuse by PSW #108 towards resident #025.

During an interview, the Director of Care indicated that she was unable to locate the licensee's internal investigation notes for the CIR. She was not the acting DOC at the time of the incident and was unable to confirm if the Director was notified of the outcome of the licensee's internal investigation. DOC #113 who was the acting Director of Care at the time is no longer employed by the licensee.

The licensee failed to ensure that the results of the alleged verbal abuse investigation was reported to the Director. [s. 23. (2)]

WN #8: 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 and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

Related to Log#033984-16

A critical incident report (CIR) was submitted to the Director on a specific date, for an incident of alleged staff to resident verbal abuse that occurred three days prior. The CIR indicated that a written report was submitted to the Director of Care by a PSW alleging that another staff member yelled at a resident for soiling his/her incontinence product when the PSW was providing care.

Resident #025 was cognitively impaired and no longer resides in the home.

Review of the CIR, clinical records including progress notes and Risk Management reports, fails to indicate that the SDM was notified of the results of the licensee's internal investigation of the allegation of verbal abuse by PSW #108 towards resident #025.

During an interview, the Director of Care indicated that she was unable to locate the licensee's internal investigation notes for the CIR. She was not the acting DOC at the time of the incident was was unable to confirm if the resident's SDM was notified of the outcome of the licensee's internal investigation. The DOC #113 who was the acting Director of Care at the time is no longer employed by the licensee.

The licensee failed to ensure that the SDM for resident #025 was immediately notified of the outcome of the alleged abuse investigation. [s. 97. (2)]

Issued on this 24th day of November, 2017

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

Original report signed by the inspector.