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
Aug 18, 2016	2016_381592_0017	019105-16, 020159-16, 020413-16, 020158-16, 016305-16, 021155-16	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

CHATEAU GARDENS LANCASTER LONG TERM CARE CENTRE
105 MILITARY ROAD NORTH P.O. BOX 429 LANCASTER ON K0C 1N0

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

MELANIE SARRAZIN (592)

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): July 21, 22, 25, 26, 27, 28 and August 02, 2016

During the course of the inspection, the inspector conducted a total of seven Critical Incidents inspections Log#: 020158-16 and 016305-16 (communication and response system), Log #: 019105-16, 020159-16, 020413-16, 021155-16 and 023439 (resident to resident alleged abuse).

During the course of the inspection, the inspector(s) spoke with the home's Administrator, the Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Behaviour Support Worker (BSO), Personal Support Worker (PSW) and residents. During the course of this inspection, the inspector observed the delivery of Resident care and services, reviewed Residents' health care records and reviewed the home policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for resident #007 that sets the planned care for the resident.

A Critical Incident was submitted to the Ministry of Health and Long Term Care regarding a resident to resident alleged sexual abuse between resident #010 and resident #007 which occurred on a specified date in May 2016.

A review of resident #007's health care record indicated that resident #007 was admitted on a specified month in 2015 with cognitive impairment and other medical issues.

A review of the resident #007's progress notes indicated that on a specified date in May 2016, resident #010 was observed rubbing resident #007's body parts and going up towards private area when he/she was stopped by the resident. Resident #010 was told by a staff member about the inappropriateness of his/her acts and stated "I just want to touch his/her private area" . Resident #010 was removed from the situation. The progress notes further indicates that resident #007 was consoled by a staff member for 10 minutes as he/she was upset over the incident.

A Critical Incident was submitted to the Ministry of Health and Long Term Care regarding a resident to resident alleged sexual abuse between resident #006 and resident #007 which occurred on a specified date in June 2016.

Upon a review of the resident #007's progress notes, it was observed that on a specified date in June 2016, resident #006 was witnessed doing inappropriate touching to resident #007. Residents were immediately separated.

A Critical Incident was submitted to the Ministry of Health and Long Term Care regarding a resident to resident alleged sexual abuse between resident #010 and resident #007 which occurred on a specified date in July 2016.

Upon a review of the resident #007's health care record, it was observed that on a specified date in July 2016, resident #010 was seen by a Registered Staff member doing inappropriate touching to resident #007. Resident #010 was immediately removed from situation.

On July 25, 2016, in an interview with PSW #106 assigned as the home's behaviroul

support ressource worker, she told Inspector #592 that she was aware of resident #006 and #010 episodes of sexual behaviours towards resident #007. She further told Inspector #592 that she was providing support and education to the PSW's on how to handle resident #006 and #010 behaviours. She told Inspector #592 that there was no specific plan interventions for resident #007 but that staff were monitoring resident #006 and #010 whereabouts.

On July 27, 2016, in an interview with RN #108 and RPN #102, they both told Inspector #592 that they were aware that resident #007 was being recently involved in alleged sexual abuse. Both staff members further told Inspector #592 that resident #007 was using a wheelchair to mobilize on the unit and was depending on staff members for his/her care. They further told Inspector #592 that resident #007 was identified as being passive and vulnerable, therefore being a target from other residents identified with sexual behaviours and who are mobilizing on their own on the unit. They both told Inspector #592 that resident #006 and #010 whereabouts were monitored but no specific planned interventions was specifically put in place for resident #007.

Upon a review of the documentation in the current written plan of care with RN #108 for resident #007 between May and July 2016, it indicated that resident #007 ability to express self and understand others was impaired. It further indicated that resident #007 has a progressive decline in cognitive functioning with other health issues. RN #108 confirmed that there was no written plan of care for resident #007 that sets a plan for maintaining a safe environment by protecting resident #007 from potential abuse from other residents. (Log #023439-16, 021155-16 and 019105-16) [s. 6. (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 to ensure that the written plan of care for resident #007 sets the planned care for resident #007 to ensure resident is safe in her environment, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system (call bell) could be easily seen, accessed and used by residents #003 and #005 at all times.

Two Critical Incidents were submitted to the Ministry of Health and Long Term Care regarding the resident-staff communication and response system failure. (Log# 020158-16 and 016305-16)

A new resident-staff communication and response system was put in place and functional at the time of the inspection.

On July 29, 2016, Inspector #592 observed a resident sitting beside his/her bed on his/her wheelchair in a specified room. The call bell was noted to be out of reach for the resident. In an interview with PSW #100, she point it out to Inspector #592 that the length of the call bell cord was to short for the resident to be accessible.

On July 22, 2016, Resident #003 was observed in a share room sitting in his/her wheelchair beside his/her bed. The call bell cord was noted to be hanging from the activation board located on the wall between resident #003's bed and co-resident's bed.

In an interview the resident stated that when he/she needs help he/she uses the call bell for assistance. The resident told Inspector #592 that he/she was not able to access his/her call bell due to his/her wheelchair being too large to fit between the two beds. He/She also told Inspector #592 that he/she would have to transfer himself/herself on his/her bed, then roll and try to stretch his/her arm to attempt to reach the call bell cord which will put him/her at risk for falls .

On the same day, Inspector #592 observed resident #005, sitting in his/her wheelchair beside his/her bed. The call bell cord was noted to be hanging from the activation board located on the wall beside the resident's night table and his/her bed. Resident #005 showed the transfer pole to inspector #592 beside his/her bed which was located in front of the activation board. Resident #005 showed Inspector #592 by moving closer with his/her wheelchair that he/she was unable to reach his/her call bell. Inspector #592 observed that the location of the night table, the bed and the transfer pole was preventing resident #005 to have access to his/her call bell.

In an interview with the Administrator, she told Inspector #592 that the home was made aware of some concerns with the new resident-staff communication and response system . She told Inspector #592 that due to the shortness of the call bell cord, that the home as ordered some extension cord to be added to the actual call bell cord. She further told Inspector #592 that in the meantime, residents identified as being capable of using their call bell were provided with a temporary extension cord. In a tour of the resident #003 and #005 rooms accompanied by the Administrator, she told Inspector that there was no extension cords provided to these residents who were both capable and that they were to have access to their call bell at all time. [s. 17. (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 to ensure that the resident-staff communication and response system could be accessed and used by resident #003 and #005 at all times, to be implemented voluntarily.

WN #3: 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 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. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).

A Critical Incident was submitted to the Ministry of Health and Long Term Care regarding a resident to resident alleged sexual abuse between resident #006 and resident #009. (Log# 020413-16)

A review of the resident #006's progress notes indicated that on a specified date in June 2016, resident #006 was observed doing inappropriate touching to co-resident #009 sitting in a chair in the home's front lounge.

According to O.Reg.79/10, s.2.(1) sexual abuse means any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A review of the resident #009's health care records indicated that resident #009 is identified with memory loss, impaired judgement and cognitive issues, therefore unable to provide any consent for sexual touching. In addition, no documentation was found in the resident #009's health care records regarding the incident of alleged sexual abuse on a specified date in June 2016.

Inspector #592 reviewed the Resident Abuse-Abuse Prevention Program-Whistle-Blowing Protection Policy #LTC-CA-ALL-100-05-02 effective date of July 2010. A review

of this Policy indicated under Procedures; to assess the resident immediately following the reporting of alleged/witnessed abuse. The Policy further indicates under Documentation; to ensure that all physical assessments/examinations are recorded with clear descriptions and details and that all entries are signed, dated with the time of documentation;
The Policy further indicates to complete a Resident Incident Report form as applicable to the home;

In an interview with RN #108, she told Inspector #592 that she was the Registered Nurse responsible for the floor on the day of the incident. She further told Inspector #592 that upon being notified of an alleged abused, a physical assessment is to be completed immediately for the residents involved in the incident to assess any signs of emotional distress or physical injuries. She further told Inspector #592 that a Resident Incident Report Form is also completed for the residents involved in the incident which describe the details and actions taken. She confirmed with Inspector #592 that she did not complete any documentation for resident #009 following the report of the alleged sexual abuse.

In an interview with the DOC and the Administrator, they both told Inspector #592 that it was the home's expectation that all events related to a reported allegation of abuse should be documented in each resident's involved in each resident health care records. They further told Inspector #592 that an assessment of the residents involved in the incident is to be completed and documented. They both told Inspector #592 that a resident incident report form should also be completed for the residents involved in the incident, which will indicate the details of the incident and the actions taken as per the home's Policy. [s. 20. (1)]

2. The licensee has failed to ensure that it complied with its policy to promote zero tolerance as per the LTCHA, 2007, S.O. 2007, c. 8, s.20(1), when the abuse of a resident was not immediately reported to the Director, as indicated under the LTCHA, 2007, S.O. 2007, c. 8, s. 20(2)(d).

According to O.Reg.79/10, s.2.(1) sexual abuse is defined as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Emotional abuse means any threatening or intimidating gesture , actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident

performing the gesture, actions, behaviour or remark understands and appreciates their consequences.

A Critical Incident was submitted to the Ministry of Health and Long Term Care regarding a resident to resident alleged sexual abuse between resident #010 and resident #007 which was reported on a specified date in July 2016. (Log# 021155-16)

Upon a review of the resident #007's health care record, it was noted that on a specified date in July 2016, resident #010 was seen by a Registered Staff member doing inappropriate touching to co-resident #007. Resident #010 was immediately removed from situation.

Upon a review of the resident #010's progress notes from April to July 2016, Inspector #592 noted that there was another incident involving resident #010 and #007 on a specified date in May 2016. The progress notes indicated that resident #010 was observed rubbing resident #007 body parts and was going for resident #007's private parts when he/she was stopped by the resident. Resident #010 was told by a staff member about the inappropriateness of his/her acts and resident #010 stated "I just want to touch his/her private area". The progress notes further indicates that resident #007 was consoled by a staff member for 10 minutes as he/she was upset over the incident.

The documented incident on a specified date in May 2016 can be determines as non-consensual as resident #007 stopped resident #010 and was consoled by a staff member for 10 minutes as he/she was upset over the incident.

The home's policy on Prevention of Abuse and Neglect of a Resident Policy Number LTC-CA-ALL-100-05-02 (dated on October 2014), indicates that abuse reporting is mandatory; all staff members are required to report any abuse, suspected abuse or allegation of abuse immediately to their respective supervisor. Failure to report abuse of any kind is subject to disciplinary action.

In an interview with the Administrator and the DOC, they both told Inspector #592 that they were not made aware of the incident and that it should have been reported immediately due to the nature of the incident which caused emotional distress to resident #007.

In an interview with RPN #110 who was present at the time of the incident, she told Inspector #592 that she has been told by the home to report any alleged abuse to the RN

in charge who will then take it higher by reporting the incident to the managers and the Director. She further told Inspector #592 that the incident which occurred on a specified date in May 2016 between resident #007 and #010 should have been reported to the Registered Staff due to resident #007's emotional distress and the sexual attempt made by resident #010. RPN #110 told Inspector #592 that she can recall why she has not reported the incident to the RN on that day.

Therefore the home did not follow the home's abuse policy by not reporting the alleged abuse. [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 to ensure that the licensee comply with their Policy to promote zero tolerance by following their procedures for investigating and responding to alleged abuse and to immediately report to the Director, to be implemented voluntarily.

WN #4: 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 has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director. (Log# 019105-16)

According to O.Reg.79/10, s.2.(1) " Sexual abuse is defined as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member;

A Critical Incident was submitted to the Ministry of Health and Long Term Care regarding a resident to resident alleged sexual abuse between resident #006 and resident #007 on a specified date in June 2016.

Upon a review of the resident #006's health care record, it was observed that on a specified date in June 2016, resident #006 was witnessed doing inappropriate touching to resident #007. Residents were immediately separated.

A review of resident #007's health care record indicated that resident #007 was admitted on a specified month in 2015 with cognitive impairment and other medical issues. It further indicates that resident #007 ability to express self and understand others was impaired.

In a review of the Critical Incident Report it was noted that the report was send to the Director, under the LTCHA the day after the incident by the DOC. It is further noted on the report under section outcome /current status that staff were provided education on the need for immediately reporting cases of sexual abuse to the Director.

During an interview with RN #103 who was in charge at the time of the incident, she told Inspector #592 that she can't recall if she had phone the Director, under the LTCHA. She further told Inspector #592 that it was the home's expectations that the charge nurse will contact the Director immediately upon becoming aware of any abuse but sometimes if the incidents occurs during the weekend, the staff will wait to report it on the next day.

During an interview with the DOC, she told Inspector #592 that following the home's internal investigation, it was determined that the RN in charge of the home the day of the incident, did not inform the Director under the LTCHA immediately. The DOC further told

Inspector #592 that she informed the Director upon becoming aware of the incident on the next day. Therefore, the information pertaining to an alleged sexual abuse was not reported immediately. [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 has reasonable grounds to suspect that abuse has occured, shall immediately report the suspicion to the Director,, to be implemented voluntarily.

Issued on this 18th day of August, 2016

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

Original report signed by the inspector.