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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 6, 2015	2015_326569_0014	009922-15	Complaint

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 London Long Term Care Centre
2000 Blackwater Road LONDON ON N5X 4K6

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

DONNA TIERNEY (569)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 30, 2015.

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Assistant Director of Care, 2 Registered Nurses, 2 Personal Support Workers, a family member, and residents.

The inspector also toured areas of the home and made observations of residents, staff to resident and resident to resident interactions, and the posting of Ministry information such as the Resident's Bill of Rights and the Action Line number.

Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed.

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.
- **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. (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 of abuse of a resident by anyone is immediately investigated.

Record review revealed there was a resident to resident altercation that resulted in a minor injury for an identified resident.

Review of the home's policy number LTC-CA-ALL-100-05-02 titled Resident Abuse-Abuse Prevention Program-Whistle-Blowing Protection with a revision date of October 9, 2014 defined physical abuse as any behaviour exhibited towards a resident, which is or may be perceived by the resident as, physical force that may or does cause injury, or inflicts pain or discomfort for the resident. It also stated "All reports of an abuse allegation are to be investigated immediately by the supervisor who receives the report."

Review of the home's complaint log and the clinical record revealed no documented evidence of a follow up investigation to the incident.

Interview with the Director of Care on July 30, 2015 confirmed that the identified resident had suffered an injury as a result of a resident to resident altercation and there was no home internal investigation of the incident. [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 that every alleged, suspected or witnessed incident of abuse of a resident by anyone is immediately investigated, to be implemented voluntarily.

WN #2: 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 home's policy that promotes zero tolerance of abuse and neglect of residents is complied with.

Record review revealed there was a resident to resident altercation that resulted in a minor injury for an identified resident.

Review of the home's policy number LTC-CA-ALL-100-05-02 titled Resident Abuse-Abuse Prevention Program-Whistle-Blowing Protection with a revision date of October 9, 2014, indicated that the home has a zero tolerance policy with respect to abuse of any kind from any person including resident to resident. It also stated that all provincial legislative reporting requirements will be followed and the Administrator/GM is responsible for initiating and completing all reports to regulatory authorities.

The Ontario legislative reporting requirements state that a person who has reasonable grounds to suspect abuse of a resident by anyone resulting in harm or a risk of harm to the resident shall immediately report the information upon which it is based to the Director.

Review of the Ministry of Health and Long Term Care (MOHLTC) Critical Incident System failed to reveal any documented submissions by the home regarding the incident.

Interview with the Director of Care on July 30, 2015, confirmed that the home did not follow their abuse policy by not reporting this incident to the MOHLTC immediately. [s. 20. (1)]

Issued on this 6th day of August, 2015

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

Original report signed by the inspector.