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
Jul 14, 2017	2017_363659_0012	011226-17	Complaint

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

Berkshire Care Centre
350 DOUGALL AVENUE WINDSOR ON N9A 4P4

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

JANETM EVANS (659)

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): June 8 and 9, 2017.

Intake IL-51192-LO/Log# 011266-17 was completed related to alleged abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, Social Services Coordinator, Environmental Services Manager, Quality Improvement Coordinator, Registered Nurses, Personal Support Workers, and Laundry Aides.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation Reporting and Complaints

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. 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 there was a written policy that promotes zero tolerance of abuse and neglect of resident and that it was complied with.

The home's abuse and neglect policy, ID RCS P-10, revised July 2, 2015 stated: "any alleged, suspected or witnessed incident of abuse or neglect of a resident is to be reported to the Administrator/designate of the home, who will immediately commence an investigation."

The policy included detailed steps for completion of an investigation which included conducting interviews with the resident or person making the report, notification to police of abuse or neglect that may constitute a criminal offence; notification of residents and substitute decision makers (SDM) of any alleged, suspected or witnessed incident; advising the perpetrator of the allegation; documenting interviews; reaching a decision and communicating the outcome.

A review of progress notes for an identified resident showed entries on two different dates where the resident had expressed concerns related to either money or personal items missing from their room or witnessing other residents being abused.

A review of the home's Client Service Response (CSR) binder did not show documented evidence of the above concerns or investigation.

A review of the home's Critical Incident binder (CI) did not show documented evidence of a Critical Incident (CI) being submitted for the allegation of residents being abused or money or other articles missing from the identified resident's room or documented investigation related to these allegations.

In interviews, Social Services Coordinator (SSC) and Director of Care (DOC) acknowledged awareness of the allegations. The DOC acknowledged that they had not completed any documentation related to the allegation nor had they submitted a Critical Incident report related to the allegations and stated the expectations for any allegation of abuse or neglect, was to do an investigation right away, put interventions in place and report to the ministry. The DOC stated that they did not expect abuse as they did not have any suspicions or facts.

The Administrator initially stated they were not aware of the resident making any allegation related to money being missing or residents' being abused The Administrator stated that the expectation was that if information went to the DOC that they should be notified and they would initiate an investigation and a CI would be completed and the Ministry of Health (MOH) would be informed. Later the Administrator stated that the resident had complained about residents being abused by staff approximately two to three years ago. The Administrator stated that there was no documentation related to these allegations. The Administrator stated that a CI was not completed for this allegation nor were police notified about the allegations of staff to resident abuse. The Administrator stated an investigation had been completed but had not been documented as the allegations were from three years ago.

The Administrator acknowledged that they had failed to follow their policy of abuse and neglect in that they failed to document an investigation into allegations of abuse and neglect.

The scope of this issue was isolated. The severity was level two - minimal harm or potential for actual harm. The home had a history of related non compliance July 3, 2014 and April 15, 2015. [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's written policy that promotes zero tolerance of abuse and neglect of a resident 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
(ii) Neglect of a resident by the licensee or staff ,or
(iii) Anything else provided for in the regulations

In an interview an identified resident reported that abuse of residents by staff began shortly after they came to the home. The resident stated they had reported this to staff.

Review of the identified resident's progress notes showed documentation related to the resident alleging concerns regarding missing money and witnessing other residents being abused by staff.

In interviews completed, Social Services Coordinator (SSC); Director of Care (DOC) and the Administrator acknowledged awareness of allegations related to abuse of residents by staff.

The DOC stated they did ignore this concern but continued to make observations. The DOC acknowledged that they had not completed any documentation related to the allegation nor had they submitted a Critical Incident report related to the allegations. The DOC acknowledged that the expectation for any allegation of abuse or neglect was to do an investigation right away, put interventions in place and report to the ministry.

The Administrator stated the resident had complained about residents being abused by staff two to three years ago. After reviewing the progress notes, the Administrator stated that they had spoken to the resident four to five months ago; there was no documentation related to this meeting.

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.

The scope of this issue was isolated. The severity was level two - minimal harm or potential for actual harm. The home had a history of related non compliance August 25, 2016. [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 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
(ii) Neglect of a resident by the licensee or staff ,or
(iii) Anything else provided for in the regulations, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

A review of progress notes for an identified resident, showed documentation related to the resident alleging concerns regarding missing money and witnessing other residents being abused.

In interviews completed Social Services Coordinator (SSC); Director of Care (DOC) and the Administrator acknowledged awareness of allegations related to abuse of residents by staff .

The Administrator stated that a Critical Incident (CI) was not completed for this allegation nor were police notified about the allegations of staff to resident abuse. The Administrator stated an investigation had been completed but had not been documented as the allegations were from three years ago.

The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse of neglect of a resident that the licensee suspects may constitute a criminal offense.

The scope of this issue was isolated. The severity was level one - minimal risk. The home had a history of related non compliance July 3, 2014 [s. 98.]

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 appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offense, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The Licensee failed to ensure that every written or verbal complaint made to the licensee or staff member concerning the care of a resident or operation of the home has:

• been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and
• where the complaint alleges harm or risk of harm to one or more residents, has the investigation commenced immediately

Review of an identified resident's progress note documented:
That there was an incident involving the identified resident; where the identified resident was struck on the head with a plastic sign. There was no apparent injury but the resident was shaken following the incident.

Review of Client Service Response (CSR) form showed the incident was documented. The documentation showed a complaint had been made to the Social Services Coordinator (SSC) by the resident's spouse and was forwarded to the nursing department. The documentation showed the complainant was met with 19 business days after submitting the concern.

In interviews the Administrator stated they were uncertain why there was a delay in responding to the incident and stated the Assistant Director of Care (ADOC) had not received the CSR until 19 days after the concern was put forward. The Administrator and ADOC stated that the form should have been forwarded to the ADOC sooner for follow up.

The home's policy on complaints documented that managers/delegates receiving a copy of the complaint will document their actions; response(s) to the complainant and complainant's response on the "Response and Resolution Report", located on the back of the form in the appropriate sections and forward the completed form to the Administrator within ten business days. All contact calls, even if there is no answer or no message is left is to be documented in the Response to Complainant section. The Administrator or delegate would contact the resident/POA complainant to discuss the completed investigation, relevant findings and document this on the form. A progress note would be included in the resident' chart as appropriate.

The Licensee failed to ensure that every written or verbal complaint made to the licensee or staff member concerning the care of a resident or operation of the home has:
• been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and
• where the complaint alleges harm or risk of harm to one or more residents, has the investigation commenced immediately [s. 101. (1) 1.]

2. The licensee has failed to ensure that a documented record is kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and

(f) any response made by the complainant.

The home's policy on complaints documented that managers/delegates receiving a copy of the complaint will document their actions; response(s) to the complainant and complainant's response on the "Response and Resolution Report", located on the back of the form in the appropriate sections and forward the completed form to the Administrator within ten business days. All contact calls, even if there is no answer or no message is left is to be documented in the Response to Complainant section. The Administrator or delegate would contact the resident/POA complainant to discuss the completed investigation, relevant findings and document this on the form. A progress note would be included in the resident' chart as appropriate.

A review of the licensee's Client Service Response (CSR) binder showed a complaint form that documented the Social Service Coordinator received a complaint on a specified date from an identified resident that they lost money from their room.

Documentation on the CSR showed that the nature of the complaint was a lost item. The form was distributed to the social service department and the Administrator. The action documented one day later that Administrator spoke to the floor staff who searched the rooms on the floor and searched the resident's belongings but did not find the money. Documentation on the back of the form for final resolution, response to complainant and additional comments were blank.

The Administrator stated that the expectation was that they go back and tell the resident the outcome of their investigation. The Administrator stated that the resident knew the outcome. The Administrator acknowledged that they had not documented all the responses on their CSR form.

The licensee failed to ensure that a documented record was kept in the home that included every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant.

The scope of this issue was isolated. The severity was level one - minimal risk. The home had a history of non- related non compliance. [s. 101. (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 every written or verbal complaint made to the licensee or staff member concerning the care of a resident or operation of the home has:
• been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and
• where the complaint alleges harm or risk of harm to one or more residents, has the investigation commenced immediately.
In addition to this the written plan of correction for achieving compliance will include a plan for ensuring that a documented record is kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant, to be implemented voluntarily.

Issued on this 15th day of August, 2017

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

Original report signed by the inspector.