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
Mar 14, 2017	2017_589641_0008	030667-16, 034185-16, 000250-17	Critical Incident System

Licensee/Titulaire de permis

CROWN RIDGE HEALTH CARE SERVICES INC
106 CROWN STREET TRENTON ON K8V 6R3

Long-Term Care Home/Foyer de soins de longue durée

WESTGATE LODGE NURSING HOME
37 WILKIE STREET BELLEVILLE ON K8P 4E4

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

CATHI KERR (641)

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): March 8, 9, 10, 2017.

This inspection was in reference to three critical incidents, Log #030667-16, Log #034185-16, related to resident to resident alleged abuse and Log #000250-17 related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Nursing (DON); Registered Nurses (RN); Registered Practical Nurses (RPN); Personal Support Workers (PSW); and Residents.
The Inspector also reviewed resident health care records; observed resident rooms; observed resident care and services; reviewed the home's policies and procedures related to Falls prevention and Abuse / Neglect; and reviewed staff annual education.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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 their written policy to promote zero tolerance of

abuse and neglect of residents was complied with.

A critical incident was submitted to the Ministry of Health and Long Term Care related to an alleged staff to resident abuse that occurred on a specified date.

On March 9, the Inspector interviewed the ADM, who indicated that they had conducted an investigation into two incidents that were brought to their attention three days after the two incidents occurred.

On a specified date, during the ADM`s investigation of the incidents, a PSW and Activity aide indicated that three days earlier, they had reported two incidents of alleged abuse by PSW #103 to RPN #104. The RPN had told them that she would be reporting this to the Director of Nursing (DON). They indicated that PSW #103 had been assisting resident #004 in the dining room when they heard the resident call out loudly and / or say "ouch". Neither staff was facing the resident nor the PSW, so they could not speak to what had happened exactly at that time. The next day the resident was observed to have bruising on the right forearm.
Further, the two staff reported to the ADM that resident #004 pushed the meal away and indicated that it wasn't wanted and before the dietary staff could bring the resident the second choice for the meal, PSW #103 was heard stating that "if you're not going to eat, then you can leave the dining room". PSW #103 then pushed the resident out of the dining room in the wheelchair, in an abrupt manner. She didn't return the resident to the dining room, but instead put the resident in their room, held the door shut from the outside, stating to the RPN that the resident needed a time out.

The ADM indicated that RPN #104 had acknowledged that she had observed PSW #103 holding the door of the resident's room shut, with the resident in the room, and indicated to the PSW that it wasn't an appropriate intervention. The RPN indicated in the investigation that when the PSW and Activity Aide came to her, she had interpreted the conversation as referring to the resident not eating proper meals and had planned to refer this to the DON.

Inspector #641 reviewed the disciplinary letter given to RPN #104, which indicated that the home's investigation into the incidents discovered that she had personal knowledge of alleged abuse regarding an employee who was reporting to her on that shift. It indicated that she had witnessed an incident were the PSW held the resident's door shut while the resident was inside, and had personally released the resident after hearing the calls for help. RPN #104 had admitted during the investigation that the behaviour of

PSW # 103 was inappropriate and that she should have reported it, but didn't. The letter further stated that the investigation uncovered that RPN #104 had been aware that PSW #103 used foul language and displayed anger in the workplace.

The home's Abuse/Neglect or Suspected Abuse/Neglect of a Resident policy No. ADM 7.0, states "any alleged, suspected or witnessed incident of abuse or neglect of a resident by anyone must be reported to a supervisor or manager immediately".

RPN #104 failed to comply with the home's policy to promote zero tolerance of abuse and neglect of a resident by immediately reporting the alleged abuse of resident #004 by PSW #103 to a supervisor or manager. [s. 20. (1)]

Issued on this 28th day of March, 2017

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

Original report signed by the inspector.