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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347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
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347 rue Preston bureau 420
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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
Sep 9, 2016	2016_293554_0018	005927-16, 023337-16	Follow up

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

BALLYCLIFFE LODGE NURSING HOME
70 STATION STREET AJAX ON L1S 1R9

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

KELLY BURNS (554)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): August 05, 22, and August 31, 2016 (onsite)

Follow Up Inspection Intake #005927-16; Intakes 023337-16 and 025696-16 were inspected concurrently during this inspection.

Summary of Intakes:
1) #005927-16 - Follow Up Inspection - specific to inspection report #2016_293554_0001, regarding LTCHA, 2007, s. 15 (2), which had a compliance due date of July 29, 2016;
2) #023337-16 - Critical Incident Report - specific to an unexpected death at the long-term care home;
3) #025696-16 - Complaint - specific to the power in the long-term care home going out two to three times a day.

Off-site inspection and or inquiries were completed during the dates of August 10-12, and August 23-24, September 02, and September 07, 2016.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Social Worker, Business Manager, Environmental Services Manager, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Family Council Chair Person, the Coroner, Service Contract Representative, Family, and Residents.

During the course of the inspection, the inspector toured the home, reviewed clinical health record of a deceased resident, reviewed contents of a Critical Incident Report, reviewed home's investigational notes specific to an identified incident, reviewed corrective action plan by the licensee regarding maintenance repairs and or replacement, reviewed maintenance binders, and reviewed home specific policies, specifically Resident Smoking, Resident Safety and Risk Management-Heat Prevention, Hot Weather, Resident Falls, Maintenance Work Order and Log Book, Preventative Maintenance and Schedules/Calendars, and Concealed Audio/Video Recording Devices.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Hospitalization and Change in Condition
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #001	2016_293554_0001	554

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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

1. The licensee failed to ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas.

Related to Intake #023337-16, for Resident #001:

The Director of Care submitted a Critical Incident Report (CIR) to the Director on an identified date, regarding an unexpected death of a resident, which was said to have occurred on a specified date. Resident #001 was found outside in the secure outdoor patio-courtyard of the long-term care home.

Resident #001 was ambulatory with a mobility aid.

According to Registered Nursing Staff (#051), the Director of Care and the Administrator, resident #001 knew the access code to exit and enter the long-term care home and the secure outside area of the home. All interviewed indicated that resident #001 would occasionally go outdoors.

Personal Support Worker #053 indicated that his/her shift began at an identified hour hours on the said date. PSW #053 indicated that he/she and his/her colleague were doing care rounds and identified that resident #001 was not in his/her room; resident #001's room lights and television were on. PSW #053 indicated that he/she and his/her colleague completed rounds and went to the nursing station to get shift report approximately 15-20 minutes following their shift start time. PSW #053 indicated asking registered nursing staff the whereabouts of resident #001. Off going registered nursing staff indicated resident #001 was not on a leave of absence. PSW #053 indicated RN #051 directed him/her, at an identified time, to check to see if resident #001 was outside in the patio-courtyard.

Personal Support Worker #053 indicated that he/she had located resident #001 in the patio-courtyard; PSW #053 shouted for another PSW to get help; RN #051 attended the scene. Resident #001 was assessed by RN #051; RN notified physicians, management and resident's family of the said incident.

The Director of Care indicated, to the inspector, that she reviewed the video surveillance recording, on an identified date, and that based on her review of the surveillance, resident #001 had been seen exiting the west corridor doors of the long-term care home and was seen entering the secure patio-courtyard at an identified time and on the said date.

Personal Support Worker #053, Registered Practical Nurse #055 and Registered Nurse

#053 all indicated not being aware of any policy or procedure in place, at the time, to supervise resident #001 or any residents using the patio-courtyard area. All indicated the patio-courtyard door is not locked, and that the said door can be accessed day, evening and night if a resident has the access code.

The Administrator and the Director of Care, both indicted that, at the time of this incident, the home did not have a written policy in place to deal with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas. [s. 9. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 failed to ensure that the written plan of care set out clear directions to staff and others who provide direct care to resident #001, specific to supervision required when resident was going outdoors.

Related to Intake #023337-16, for Resident #001:

The Director of Care submitted a Critical Incident Report (CIR) to the Director on an identified date, regarding an unexpected death of a resident, which was said to have occurred the previous date, on or before a specified hour. Resident #001 was found in the outdoor patio-courtyard of the long-term care home.

According to Registered Nursing Staff, the Director of Care and the Administrator, resident #001 had known the access code to exit and enter the long-term care home. All interviewed indicated that resident #001 would occasionally go outdoors.

The written plan of care, for resident #001, was reviewed by the inspector; the plan of care identifies the following:
- Resident required supervision when ambulating with a mobility aid; required reminders to use the mobility aid
- Resident was required to be reminded to walk slowly when going from location to location.
- Resident would opt to stay in his/her room throughout the day when he/she had been in a an identified state
- Resident had smoked cigarettes occasionally.
- Had been identified as high risk for falls

The licensee's policy, Resident Smoking (#LTC-CA-ALL-100-05-06) directs the following:

- A residents' care plan must identify if the resident smokes. Residents who smoke must be deemed safe to smoke without supervision. Residents who are assessed as a risk to smoke independently must have arrangements made by the resident themselves as part of the care/support plan to have a responsible person for continuous supervision during smoking times. The Residence may provide this supervision for designated periods, this must be identified on the resident's care plan.
- All residents who are smokers may be assessed for safe smoking by registered nursing staff which includes a review of physical and cognitive abilities. If the assessment indicates that smoking independently may be a risk and requires supervision this must be addressed as part of the care plan.

Personal Support Worker #053 and Registered Nurse #051 both indicated resident #001 had been located in the outside patio-courtyard area with his/her mobility aid.

Personal Support Worker #053, Registered Practical Nurse #055 and Registered Nurse #051 all indicated not being aware of any specific plan of care which directed staff and others who provide direct care to resident #001, specifically direction around supervision while outdoors or when resident #001 was smoking in the secure patio-courtyard or other designated locations. All indicated resident #001 had known the access code for the

patio-courtyard door and that he/she could access the patio-courtyard day, evening and night if he/she chose to do so. All interviewed further indicated, there had been no direction around how resident #001 was to have been supervised while ambulating with his/her walker. [s. 6. (1) (c)]

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 there is a process in place and monitored, ensuring the written plan of care set out clear directions to staff and others who provide direct care to residents, to be implemented voluntarily.

WN #3: 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 a resident-staff communication and response system is available in every area accessible by residents.

During this inspection, there was no resident-staff communication and response system observed in the secure patio-courtyard area of the long-term care home. Residents were observed walking about and sitting in this area, during the dates of August 05, and August 22, 2016.

The Administrator acknowledged that there is no means for a resident to communicate to staff when residents are using this said area. [s. 17. (1) (e)]

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 there is a resident-staff communication and response system available in the secure patio-courtyard area, to be implemented voluntarily.

Issued on this 9th day of September, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY BURNS (554)
Inspection No. / No de l'inspection :	2016_293554_0018
Log No. / Registre no:	005927-16, 023337-16
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Sep 9, 2016
Licensee / Titulaire de permis :	Chartwell Master Care LP 100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1
LTC Home / Foyer de SLD :	BALLYCLIFFE LODGE NURSING HOME 70 STATION STREET, AJAX, ON, L1S-1R9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Duna McKay

To Chartwell Master Care LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Order / Ordre :

The licensee shall prepare, implement and submit a corrective action plan to ensure that there is a written policy regarding when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas.

Licensee shall:
- Develop and implement a written policy regarding doors leading to secure outside areas, and access to the said areas. The policy must include clear direction to staff and others, specific to the required supervision and safety needs of residents utilizing these areas.
- Communicate the said written policy to residents, resident families, visitors and staff of the long-term care home.
- Implement a process to ensure that the policy regarding locking, unlocking of doors and permitting or restricting unsupervised access to secure outside areas is adhered to by the staff, management and others.

The licensee shall provide the written plan on or before September 16, 2016. The plan must be submitted in writing and forwarded to the attention of: Kelly Burns, LTC Homes Inspector (Nursing), via fax, at (613) 569-9670.

Grounds / Motifs :

1. The licensee failed to ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas.

Related to Intake #023337-16, for Resident #001:

The Director of Care submitted a Critical Incident Report (CIR) to the Director on an identified date, regarding an unexpected death of a resident, which was said to have occurred on a specified date. Resident #001 was found outside in the secure outdoor patio-courtyard of the long-term care home.

Resident #001 was ambulatory with a mobility aid.

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Personal Support Worker #053 indicated that his/her shift began at an identified hour hours on the said date. PSW #053 indicated that he/she and his/her colleague were doing care rounds and identified that resident #001 was not in his/her room; resident #001's room lights and television were on. PSW #053 indicated that he/she and his/her colleague completed rounds and went to the nursing station to get shift report approximately 15-20 minutes following their shift start time. PSW #053 indicated asking registered nursing staff the whereabouts of resident #001. Off going registered nursing staff indicated resident #001 was not on a leave of absence. PSW #053 indicated RN #051 directed him/her, at an identified time, to check to see if resident #001 was outside in the patio-courtyard.

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Personal Support Worker #053, Registered Practical Nurse #055 and Registered Nurse #053 all indicated not being aware of any policy or procedure in place, at the time, to supervise resident #001 or any residents using the patio-

courtyard area. All indicated the patio-courtyard door is not locked, and that the said door can be accessed day, evening and night if a resident has the access code.

The Administrator and the Director of Care, both indicted that, at the time of this incident, the home did not have a written policy in place to deal with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas. (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 9th day of September, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kelly Burns

Service Area Office /
Bureau régional de services : Ottawa Service Area Office