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 prévue le Loi de 2007 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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jan 04, 2017;	2016_360111_0031 (A1)	031481-16	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

Chartwell Ballycliffe Long Term Care Residence
70 STATION STREET AJAX ON L1S 1R9

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

LYNDA BROWN (111) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Hello Ms. McKay,
Here is the amended inspection report and order with new action plan due date and compliance due date as requested.
thanks
Lynda Brown

Issued on this 4 day of January 2017 (A1)

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

Original report signed by the inspector.

Ontario

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

LYNDA BROWN (111) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

Rapport d’inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

This inspection was conducted on the following date(s): November 17, 18, 29, 2016

A complaint inspection was completed related to responsive behaviours, falls, complaints, and personal care.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurse (RPN), Personal Support Workers(PSW), private care workers, and residents.

During the course of the inspection, the inspector(s) also reviewed health records of residents, reviewed the home's policies: complaints and code yellow, reviewed the home's complaints, reviewed investigations and code yellow reports.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Reporting and Complaints

Responsive Behaviours

Safe and Secure Home

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

4 WN(s)
1 VPC(s)
1 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The licensee failed to ensure the home is a safe and secure environment for its residents.

Review of the health care record for resident #001 indicated the resident was admitted with a diagnosis that included cognitive impairment. Review of the progress notes for 2016 indicated the resident demonstrated ongoing high risk for self injury responsive behaviours.

Interview with the DOC by Inspector #111, during this inspection, indicated code yellow checklist, internal incident report and an investigation was to be completed for any missing resident incidents. The DOC was requested to provide same to the inspector but no documented code yellow checklist or investigation was provided as completed for the third and fourth incident.

Review of the progress notes, code yellow checklists, interview of staff, and review of the home's investigation notes indicated the resident had 4 incidents of being missing. The last incident was not reported to the Director. Two of the incidents were related to doors that were not locked. The third and fourth incident had no documented evidence an investigation was completed or actions taken to prevent a recurrence.

Review of the home's investigation for the second incident related to resident #001 and review of the progress notes indicated there was conflicting information related to the length of time the resident was missing (approximately one hour). Review of the code yellow checklist for the second incident of missing resident indicated the only action taken to prevent a recurrence was maintenance to repair the door closing mechanism.

Review of the written plan of care plan for resident #001 indicated the resident demonstrated wandering, exit-seeking and elopement responsive behaviours. Interventions included to initiate a DOS every 30 minutes to ensure safety`` and is wandering safely but no indication when this is to be used

Although the scope was related to only one resident, the severity was high as the resident was a high risk for elopement and had more than one incident of elopement. The home failed to ensure resident #001 was kept safe and secure in

the home as: the resident was able to enter areas that were to be kept locked when unattended and the resident was able to exit the home on more than one occasion and staff were not aware the resident was missing. There was no investigation completed by the home related to the resident being found in an area unsupervised or unlocked to determine how long the resident was missing or how the resident entered the area. There was no investigation completed by the home related to the resident being found outside to determine how long the resident had been missing or how the resident exited the home. There were no other actions taken by the home until the home implemented 1:1 staffing which was put in place after the resident was found outside and this incident was also not reported to the Director.

In addition, the home's compliance history indicated a compliance order was warranted as O.Reg. 79/10, s.5 was previously issued as a CO on May 6, 2016 during the RQI inspection and issued as a VPC on June 20, 2016 during a Critical incident inspection. [s. 5.]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

The licensee failed to ensure that when the resident had fallen and the resident was being reassessed, the plan of care was revised because care set out in the plan had not been effective, and different approaches were considered in the revision of the plan of care.

Review of the progress notes for resident #001indicated the resident sustained nine falls in six months. The first, second and third, fifth, sixth and eighth fall had no actions identified as taken to prevent recurrence. The fourth fall indicated the action identified to prevent recurrence: "ongoing monitoring as the resident continues to walk unsafely without use of" mobility aides but no clear direction how and when this was to occur. After the seventh fall, a referral form was completed for OT/PT. After the ninth fall, the resident was assessed by PT and indicated "unable to follow directions, not able to weight bear safely, needs SARA lift for transfers, and logo changed".

Interview of staff by Inspector #531 during this inspection, indicated the resident was a high risk for falls due to unsteady gait, restlessness, anxiety, cognitive impairment and forgetting and/or refusing to use mobility aides when ambulating. The staff indicated the resident would also remove the chair alarms when applied. The staff indicated the resident has had 1:1 staff recently put for close monitoring as the resident was very unpredictable.

Review of the current written care plan for resident #001, by Inspector #111, indicated the resident was a high risk for falls as the resident will often remove alarming devices, and refused and/or forgets to use mobility aides. The following interventions were in place prior to the first fall which included: staff to ensure hip

protectors in place; remind to call for assistance; alarming devices in place and checked on rounds through the night; bed in lowest position for safety; ensure proper non-slip footwear is in place while up at all times; leave bathroom light on at night; place mobility aide at bedside at night; remind to remain and or use mobility aides. An additional intervention was added after the sixth fall to ensure visual correction is worn when up.

Review of the post fall analysis assessment tools indicated only 7out of 9 falls had the assessment tool completed. One post fall analysis assessment tool was completed after the seventh fall and had action taken to prevent recurrence was a referral to Physiotherapy (PT). The referral was not completed by PT until 17 days later, after two more falls occurred. The remainder eight assessment tools had no actions selected to prevent a recurrence. [s. 6. (11) (b)]

Interview with staff indicated the 1:1 PSW had only been in place for a specified period of time as a result of last fall and during the 1:1, the interventions such as alarming devices are not used.

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 when the residents at high risk for falls are reassessed, the plan of care is reviewed and revised, when the care set out in the plan has not been effective and different approaches are considered to reduce the incidence or risk of injury to the residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

The licensee failed to ensure that when the resident had fallen, the resident had been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A complaint from the Substitute Decision Maker (SDM) of resident #001 was received by the Director regarding concerns over the number of falls the resident had been sustaining.

Review of the progress notes for resident #001 indicated the resident sustained nine falls in six months.

Interview with the DOC by Inspector #111 during this inspection, indicated an electronic post fall analysis form is to be completed after each fall and the post fall analysis form provided a list of actions to be taken to prevent a recurrence.

Review of the post fall analysis assessment tools indicated only seven out of nine falls had the assessment tool completed. One post fall analysis assessment tool (completed after the seventh fall) had action taken to prevent recurrence was a referral to Physiotherapy (PT). The referral was not completed by PT until 17 days later, and after two more falls occurred. The remainder eight assessment tools had no actions selected to prevent a recurrence.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

Review of the progress notes for resident #001 indicated on a specified date and time, the resident was found missing less than three hours outside the home and was returned with no injuries. The resident was not reported as missing by the PSW.

Interview with the DOC regarding the incident and review of the critical incident system indicated the incident was not reported to the Director.
The resident was missing less than 3 hours and returned to the home with no injuries and the incident was not reported to the Director.

Issued on this 4 day of January 2017 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : LYNDA BROWN (111) - (A1)

Inspection No. / No de l'inspection : 2016_360111_0031 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 031481-16 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Jan 04, 2017;(A1)

Licensee / Titulaire de permis : Chartwell Master Care LP
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

LTC Home / Foyer de SLD : Chartwell Ballycliffe Long Term Care Residence
70 STATION STREET, AJAX, ON, L1S-1R9

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Duna McKay

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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 :

LTCHA, 2007, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

(A1)
The licensee shall prepare, implement and submit a corrective action plan to ensure:
-that all doors leading to a non-residential area are monitored to ensure they are kept closed and locked when they are not being supervised by staff (including tub/shower rooms and offices),
-the plan of care is reviewed for resident #001, and any other residents at risk for exit seeking or elopement to ensure interventions are in place to monitor these residents and actions are taken to effectively mitigate risks with these responsive behaviours,
-all staff is retrained on the home's code yellow policy for missing residents to ensure the policy is developed and complied with,
-a process is developed to ensure all incidents of missing residents are investigated and appropriate actions are taken and retrain all management once this process is ready to be implemented
-regular monthly audits are carried out to assess the effectiveness of the staff response to incidents of missing persons until compliance with the home's policy is achieved.

This plan is to be submitted via fax: 1-613-569-9670 or via email to: Ottawa.SAO.MOH@ontario.ca to the attention of Lynda Brown, LTC Nursing Inspector for the Ministry of Health and LongTerm Care by January 9, 2016.

Grounds / Motifs :

1. The licensee failed to ensure the home is a safe and secure environment for its residents.

Review of the health care record for resident #001 indicated the resident was admitted with a diagnosis that included cognitive impairment. Review of the progress notes for 2016 indicated the resident demonstrated ongoing high risk for self injury responsive behaviours.

Interview with the DOC by Inspector #111, during this inspection, indicated code yellow checklist, internal incident report and an investigation was to be completed for any missing resident incidents. The DOC was requested to provide same to the inspector but no documented code yellow checklist or investigation was provided as completed for the third and fourth incident.

Review of the progress notes, code yellow checklists, interview of staff, and review of the home's investigation notes indicated the resident had 4 incidents of being missing. The last incident was not reported to the Director. Two of the incidents were related to doors that were not locked. The third and fourth incident had no documented evidence an investigation was completed or actions taken to prevent a recurrence.

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Review of the written plan of care plan for resident #001 indicated the resident demonstrated wandering, exit-seeking and elopement responsive behaviours. Interventions included to initiate a DOS every 30 minutes to ensure safety`` and is wandering safely but no indication when this is to be used

Although the scope was related to only one resident, the severity was high as the resident was a high risk for elopement and had more than one incident of elopement. The home failed to ensure resident #001 was kept safe and secure in the home as: the resident was able to enter areas that were to be kept locked when unattended

and the resident was able to exit the home on more than one occasion and staff were not aware the resident was missing. There was no investigation completed by the home related to the resident being found in an area unsupervised or unlocked to determine how long the resident was missing or how the resident entered the area. There was no investigation completed by the home related to the resident being found outside to determine how long the resident had been missing or how the resident exited the home. There were no other actions taken by the home until the home implemented 1:1 staffing which was put in place after the resident was found outside and this incident was also not reported to the Director.

In addition, the home's compliance history indicated a compliance order was warranted as O.Reg. 79/10, s.5 was previously issued as a CO on May 6, 2016 during the RQI inspection and issued as a VPC on June 20, 2016 during a Critical incident inspection. [s. 5.] (111)

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

Feb 28, 2017(A1)

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

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

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

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
Toronto ON M5S 2B1
Télécopieur : 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
Toronto ON M5S 2B1
Télécopieur : 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 4 day of January 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

Service Area Office /
Bureau régional de services : Ottawa