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 15, 2017	2017_590554_0006	026582-16, 026867-16, 027138-16, 028945-16, 033213-16	Critical Incident System

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

KELLY BURNS (554)

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): January 30-31, and February 01-03, 2017

Intakes #026582-16, 026867-16, 027138-16, 028945-16 and #033213-16

Summary of Intakes:
1) #026582-16 - Critical Incident Report (CIR) - Improper / Incompetent treatment of a resident that results in harm or risk to a resident;
2) #026867-16 - CIR - Improper / Incompetent treatment of a resident that results in harm or risk to a resident;
3) #027138-16 - CIR - Alleged abuse and neglect, resident to resident (physical);
4) #028945-16 - CIR - Alleged abuse and neglect, resident to resident (physical);
5) #033213-16 - CIR - Incident that causes an injury to a resident for which the resident is taken to hospital, and which results in a significant change in the resident's health status.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Registered Nurse(s), Registered Practical Nurse(s), Personal Support Worker(s), RPN-Quality Nurse, RAI-Coordinator, Social Worker, Housekeeping Aid, Dietary Aid, Physio-Therapy Aid, Behaviour Support Staff, Program and Support Services Manager, Residents and Families.

During the course of the inspection, the inspector toured the long-term care home; reviewed clinical health records for identified residents; observed staff to resident interactions, and resident to resident interactions; reviewed the licensee's investigational notes, complaints log and workbook, annual education for 2016, specific to zero tolerance of abuse and or neglect, complaints management, resident rights, mandatory reporting and falls prevention and management, and related program evaluations. Reviewed the licensee's policies, related to, Resident Falls, Complaints, Investigations, Resident Abuse-Abuse Prevention Program, Abuse Allegations and Follow Up, Abuse Free Communities-Prevention and Education, Assistance with Personal Hygiene, Personal Care, Continence Care, and Responsive Behaviours.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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

- **4 WN(s)**
- **3 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that persons who had reasonable grounds to suspect that, abuse of a resident by anyone, immediately report the suspicion and the information upon which it was based to the Director.

Under LTCHA, 2007, s. 2 (1), for the purposes of the definition of "abuse", the Act describes physical abuse to include, the use of physical force by a resident that causes physical injury to another resident.

Related to Intake #027138-16, related to Resident(s) #005 and #006:

The Director of Care (DOC) submitted a Critical Incident Report (CIR) to the Director, on an identified date and time. The CIR is specific to resident to resident physical abuse, involving resident(s) #005 and #006. The CIR (and associated progress notes) indicated the following was alleged to have occurred:

- Resident #006 approached Registered Nurse (RN) #051 at the nursing station, resident was bleeding, and was assessed to have bruising. When asked by RN #051 what happened, resident #006 proceeded to his/her room, where he/she pointed to resident #005, who was sitting on resident #006's bed; resident #006 stated that resident #005 had hit him/her. Both residents were separated. Resident #006 was provided first aid, placed on head injury routine and was monitored. Substitute decision makers and police

were notified of the alleged abuse incident.

As per the licensee's investigation, review of progress notes (dated for a specific time period) and interviews with registered nursing staff, and the Director of Care. Staff and or managers who had direct knowledge of this incident included, RN #051, who was the RN Supervisor, Quality Nurse (RPN #054) and the Director of Care.

According to the licensee's investigational notes, Registered Nurse (RN) #051 indicated that he/she did not notify the Ministry of Health and Long-Term Care (MOHLTC) as he/she was assessing the situation that had occurred and was providing first aid to resident #006. RN #051 indicated it was his/her understanding, on that date, that the Director of Care was notifying MOHLTC of the abuse incident.

Director of Care indicated (to the inspector, on January 30, 2017) that the Director was not notified of the resident to resident physical abuse incident, which occurred on the identified date, until the CIR was submitted approximately twenty-six hours post incident.

Director of Care indicated being aware that the Director should have been immediately notified of the resident to resident abuse. [s. 24. (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 there is a process in place and monitored ensuring, that persons who had reasonable grounds to suspect that, abuse of a resident by anyone, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The 24-hour admission care plan must identify the resident and must include, at minimum, any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks.

Related to Intake #033213-16, for Resident #009:

Resident #009 was admitted to the long-term care home on an identified date. The resident has history which includes visual and cognitive impairment.

Registered Nursing Staff completed a MORSE Risk Assessment (related to Falls Risk) for resident #009 on admission. The MORSE Risk Assessment indicated that resident #009 was at high risk for falls.

The 24-hour admission (written) care plan for resident #009 was reviewed (by the inspector, on January 30, 2017), this review failed to provide documentation of resident #009 being identified as being at risk for falls, and further failed to provide interventions to mitigate the risk, specific to falls, for this resident.

Resident #009 had a fall on an identified date, which resulted in injury and transfer to an acute care facility.

Registered Practical Nurse #070 and Registered Nurse #071 both indicated (to the inspector, on January 30, and February 03, 2017) that the 24-hour admission care plan, for resident #009, should have identified the risk for falls and have indicated interventions for this resident, specific to falls prevention and management. [s. 24. (2) 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 there is a process in place and monitored ensuring, the admission care plan identifies the resident and must include, at minimum, include any risks that the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks, to be implemented voluntarily.

WN #3: 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. (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 a documented record is kept in the home that includes, the nature of each verbal (or written complaint), the date the complaint was received, the type of action taken to resolved the complaint, including date of the action, time frames for actions to be taken and any follow-up action required, the final resolution if any, every date on which any response was provided to the complainant, and a description of the response, and any response made by the complainant.

Related to Intake #026867-16, for Resident #003:

The Director of Care (DOC) submitted a Critical Incident Report (CIR) to the Director on an identified date and time. The CIR was submitted as a mandatory report, specifically improper/incompetent treatment of a resident that results in harm or risk to the resident. Details contained within the CIR are as follows:

- On an identified date, and time, resident #003's substitute decision maker (SDM) approached the DOC, reporting that he/she entered resident's (#003) room while two personal support workers were finishing care; SDM indicated resident was crying. Resident #003 indicated being in discomfort to his/her SDM. DOC indicated that SDM believed the two personal support workers were surprised by his/her presence and further believed that personal support workers were doing something wrong. DOC indicated in CIR that SDM was rushing out of the long-term care home and indicated he/she would meet with DOC at a later date about this concern.

The Ministry of Health and Long-Term Care (MOHLTC) after-hours notification centre was contacted by the Director of Care on the identified date and time (SAC #13153).

The Director of Care indicated (to the inspector, on January 30, 2017) that resident #003's substitute decision maker had approached her in the hallway during the late afternoon-evening on the identified date, to voice concern that two personal support workers were causing discomfort to resident #003. The DOC indicated that SDM (of resident #003) was not able to identify personal support workers by name but gave a description. The Director of Care (initially) indicated she had not documented the actual concern and/or complaint by resident #003's substitute decision maker on the identified date in her day planner and was unsure if such had been documented elsewhere.

Director of Care was unavailable for interviews after January 30, 2017.

The Complaints Log and Worksheets were provided to the inspector (by the Administrator) for a two month period. This review provided documentation of the following:

- On an identified date – Registered Nursing Staff indicated in a progress note that SDM (of resident #003) was upset that resident was not at Bingo. Registered Nursing Staff indicated to SDM that perhaps resident had refused. Telephone voice message left on Program and Support Services Managers phone by recreation staff and registered nursing staff to follow up next day.

- On an identified date – Program and Support Services Manager contacted SDM (of resident #003) as to resident not attending bingo on the evening in question. Resident #003 had refused, despite encouragement by recreation staff. During this conversation, SDM indicated to Program and Support Services Manager that he/she was concerned about resident having discomfort with care. Program and Support Services Manager placed SDM on hold (on phone) and asked that the Director of Care speak with SDM; the call was transferred to DOC.

Program and Support Services Manager indicated (to the inspector, on February 02, 2017) that he/she spoke with the Director of Care about resident #003's SDM's concerns on the identified date and transferred the call from SDM to the DOC on the same date. Program and Support Services Manager indicated he/she is not aware of what the concern and or complaint was specific to care and discomfort, as that is not his/her department and he/she did not wish to know specific details.

The Administrator indicated (to the Inspector, on February 03, 2017) that she had spoken to the Director of Care, who indicated she did not received the call from SDM (of resident #003) but had received a telephone voice message from the SDM on the date in question. The Administrator indicated that DOC had attempted to return SDM's call without success on that date.

The Complaints Log and/or Worksheets (for the above) review period, fails to provide documentation:

- As to the nature a verbal complaint (on the dated identified) and neither is there documentation as to the type of action taken to resolve the complaint, including date of action, time frames for action to be taken and any follow-up action required, dates and details of response which was provided to the complainant, final resolution and any responses from the complainant, specific to this complaint;
- related to the complaint and or concern by SDM (of resident #003) on the identified date, there is no recorded documentation as to the nature of the verbal complaint received by SDM and or dates for action to be taken by DOC or others specific to this same complaint.

The Administrator indicated, it is the policy and practice of the long-term care home, that all verbal (and written) complaints will be documented in either the complaints log and or worksheets. [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 there is a process in place and monitored ensuring, that a documented record is kept in the home that includes, the nature of each verbal (or written complaint), the date the complaint was received, the type of action taken to resolved the complaint, including date of the action, time frames for actions to be taken and any follow-up action required, the final resolution if any, every date on which any response was provided to the complainant, and a description of the response, and any response made by the complainant, to be implemented voluntarily.

WN #4: 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 failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

Under O. Reg. 79/10, s. 2 (1) - For the purposes of the definition of "abuse" in subsection 2 (1) of the Act,
- emotional abuse includes, any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident;
- verbal abuse includes, any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading

nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

Under O. Reg. 79/10, s. 5 – For the purposes of the Act and this Regulation,
- neglect means, the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Related to Intake #026582-16, for Resident #001 and #002:

The Director of Care submitted a Critical Incident Report (CIR) on identified date, specific to Improper/Incompetent treatment that results in harm or risk to a resident. The alleged incidents occurred a day earlier.

Details of the CIR are as follows:

- Registered Practical Nurses (RPN) #053 and #054 submitted written concerns, to the Director of Care, regarding Personal Support Worker (PSW) #055, concerns were specific and alleged that PSW #055 was not providing planned care to residents, specifically residents #001 and #002. The written statements, by the two registered nursing staff, further indicated that PSW #055 was heard speaking inappropriately to resident #001 while showering the resident, and later heard using foul language in the presence of other residents, who were sitting in a resident lounge.

The Director of Care indicated (to the inspector, on January 30, 2017) that the CIR was submitted as the concerns voiced by RPNs were related to care of residents and were believed to demonstrate abuse and or neglect towards residents. Director of Care indicated that she became aware of the allegations on an identified date, following the alleged incident.

The licensee's policy, Abuse Allegations and Follow Up (#LTC-CA-WQ-100-05-02), and Abuse Free Communities-Prevention, Education and Analysis (#LTC-CA-WQ-100-05-18) directs the following:
- Mandatory reporting by all persons, means all persons who have reasonable grounds to suspect that any of the following events occurred or may occur, are legally obligated to immediately report the suspicion and the information upon which it is based to regulatory bodies including, MOHLTC Director. Events include (but not limited too), improper/incompetent treatment or care of a resident that resulted in harm or risk of

harm; and abuse of a resident by anyone, or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
- All employees are required to, as a component of Chartwell's internal reporting structure to ensure safety for all, and immediately report to their respective supervisor and or person in charge of the building when, abuse is witnessed, suspected and or at any time information or knowledge of an allegation of an abuse is received or learned from any person.

Registered Practical Nurse (RPN) #053 indicated (to inspector, on January 31, 2017) that he/she had heard PSW #055 speaking inappropriately (swearing) in front of residents who were sitting in a lounge. RPN #053 indicated it was his/her belief that all residents seated in the lounge (on the identified date) would have overheard the PSW; RPN indicated that there would have been ten to fifteen residents in the lounge. Registered Practical Nurse #053 indicated, that on the same date, PSW #055 had not provided planned care to residents #001 and #002. Registered Practical Nurse #053 indicated resident #001 was not provided nail care following his/her bath, and that resident #002 was not provide nail care and was left with wet hair following his/her bath on that same date. Registered Practical Nurse #053 indicated PSW #055 frequently does not provide nail care, shaves or hair care to residents assigned to have baths and showers. Registered Practical Nurse #053 indicated that residents had voiced concerns to him/her in the past specific to care not being provided by PSW #055; RPN indicate that he/she could not recall dates and or individual residents who voiced concerns. Registered Practical Nurse indicated that he/she has reported his/her concerns to RN-Supervisor #071 and the Director of Care in the past, but could not recall specific dates of these reports. Registered Practical Nurse #053 indicated it was his/her belief that the actions of PSW #055 on the identified date, were abusive and neglectful.

Registered Practical Nurse #054 was not available for an interview during this inspection.

Registered Practical Nurse #053 indicated that abuse and or neglect if suspected is to be immediately reported to his/her supervisor. RPN #053 indicated that he/she had not reported his/her concerns to the RN-Supervisor and or the Director of Care on the identified date, and that his/her concerns were documented and presented to the Director of Care, the next day. [s. 20. (1)]

Issued on this 15th day of March, 2017

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

Original report signed by the inspector.