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 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 24, 2019	2019_715672_0002	005106-18, 020292-18, 023838-18, 025002-18, 025631-18, 028300-18, 004691-19	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

JENNIFER BATTEN (672)

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 25-29 and April 1, 2, 2019

The following logs were inspected during this inspection:

Logs #025002-18, #004691-19, #025631-18 - Related to allegations of resident to resident abuse
Log#005106-18 - Related to an allegation of staff to resident abuse
Log#020292-18 - Related to an incident of improper/incompetent care
Logs #028300-18 and #023838-18 - Related to resident falls

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents, family members, visitors to the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 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	Légende 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

Related to Log #020292-18:

A Critical Incident Report was submitted to the Director on a specified date, related to an incident of improper/incompetent treatment of a resident, involving resident #008 and PSW #102. According to the CIR, PSW #102 was assisting resident #008 with personal care, transferring to bed and bed mobility. After PSW #102 assisted transferring the resident to the bed, resident #008 was observed to have sustained an identified number of injuries.

During record review, Inspector #672 reviewed resident #008's MDS assessment and written plan of care in place at the time of the incident, which indicated that resident #008 required a specified type of transfer with a specified number of staff members to assist; required a specified level of assistance from a specified number of staff members for bed mobility; utilized a specified type of personal assistive device; and had a history of several types of responsive behaviours. Based on the resident's care needs, a specified number of staff members were to be utilized at these times to provide care in a manner as described in the plan of care, in an effort to decrease the resident exhibiting the identified responsive behaviours.

During an interview, PSW #102 indicated on a specified date they had provided resident #008 with personal care with a specified number of staff different than the written plan of care instructed. PSW #102 then transferred the resident into the bed with a specified number of staff members which was different than the written plan of care instructed and using a different type of transfer method than the written plan of care instructed. PSW #102 further indicated that following the transfer, resident #008 suddenly exhibited a specified responsive behaviour. PSW #102 indicated they did not observe the injuries to the resident until after the resident had been transferred into the bed and indicated the injuries may have been caused by the resident exhibiting the specified exhibited responsive behaviour. PSW #102 further indicated they were frequently assigned to resident #008 to provide care, and would not use the specified number of staff members or the specified type of transfer listed in the resident's written plan of care, due to resident #008's refusal, but had an awareness of the directions listed in the written plan of care.

During an interview, resident #008 was unable to recall the incident or the injuries sustained on the specified date.

During an interview, RN #103 indicated being called to resident #008's room on the

specified date, and found the resident sitting up on the side of the bed, with identified injuries. RN #103 indicated resident #008 did not appear to be exhibiting a specified responsive behaviour at that time and allowed the specified injuries to be cared for. RN #103 further indicated that through conversation with resident #008 following the incident, the resident was able to indicate they had been assisted with personal care and transferred into bed with the assistance of a specified number of staff members using a specified type of transfer, which were different than those listed in the written plan of care.

Inspector #672 reviewed the internal investigation notes into the incident, which indicated that PSW #102 had not followed the directions listed in resident #008's plan of care, specific to personal care, transfers and bed mobility, and had not utilized a specified mobility device during the transfer. The internal investigation notes further indicated a belief that while PSW #102 instructed resident #008 to utilize a specified type of personal assistive device during the transfer, the a specified personal assistive device malfunctioned, possibly causing resident #008's injuries. Following the internal investigation the specified personal assistive device was replaced by a different type of personal assistive device.

During an interview, the DOC verified the findings and outcome of the internal investigation, as outlined in the internal investigation notes. The DOC indicated the expectation in the home was for all staff to provide care to each resident as outlined in the resident's plan of care. The DOC further indicated if staff found that the resident plan of care was ineffective or incorrect, they were to immediately report to the charge nurse on duty and the nurse was to immediately update the plan of care to correctly reflect the current care needs of the resident.

The licensee failed to ensure that care set out in resident #008's plan of care was provided to the resident as specified in the plan, which resulted in the resident sustaining an identified number of injuries. [s. 6. (7)]

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 resident plans of care are provided to each resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included any identified responsive behaviours or any potential behavioural triggers and variations in resident functioning at different times of the day.

Related to Log #025002-18:

A Critical Incident Report was submitted to the Director on a specified date, related to an incident of resident to resident abuse between residents #012 and #013. According to the CIR, RN #121 observed residents #012 and #013 to be sitting in an identified area, displaying a responsive behaviour at each other. Resident #013 made a movement which caused an identified injury to resident #012. Resident #013 did not sustain any injuries. According to the CIR, resident #012 was exhibiting with specified responsive behaviours, and a co-resident attempted to assist the resident in a specified manner. Resident #012 reacted by exhibiting further specified responsive behaviours.

Inspector #672 reviewed resident #012's progress notes for a specified time period. During this time frame it was observed that resident #012 had a specified number of

incidents of exhibiting identified responsive behaviours.

Inspector #672 then reviewed resident #012's written plan of care in place during this time, and observed that there was no mention of resident #012 exhibiting identified responsive behaviours. There was also no documented triggers or interventions found pertaining to the identified responsive behaviours.

During separate interviews, RPN #114, the BSO RPN and the RAI Coordinator all indicated that resident #012 had a history of exhibiting identified responsive behaviours. They further indicated that resident #012 did appear to have some triggers to the exhibited responsive behaviours. They also indicated that resident #012's identified exhibited responsive behaviours appeared to worsen during a specified time of day due to an identified reason.

During separate interviews, the DOC and the RAI Coordinator both indicated that the expectation in the home was that if a resident exhibited identified responsive behaviours, the resident should have a responsive behaviour plan of care, which included any identified responsive behaviours, any potential behavioural triggers to the responsive behaviours, and any variations in resident functioning at different times of the day. They further indicated that resident #012 should have had this focus in the plan of care as soon as the resident began to exhibit the identified responsive behaviours.

The licensee failed to ensure that resident #012's responsive behaviour plan of care included the identified exhibited responsive behaviours; the potential behavioural triggers which were known to lead to the exhibited responsive behaviours; and the variations in resident #012's functioning at different times of the day. [s. 26. (3) 5.]

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 each resident plan of care is inclusive of all responsive behaviours exhibited by the resident, and is based on an interdisciplinary assessment of the resident, which includes any identified responsive behaviours or any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #3: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written report to the Director included the analysis and follow-up action, including the immediate actions that were taken to prevent a recurrence, and the long-term actions planned to correct the situation and prevent a recurrence.

Related to Log #020292-18:

A Critical Incident Report was submitted to the Director on a specified date, related to an incident of improper/incompetent treatment of a resident, involving resident #008 and PSW #102. According to the CIR, PSW #102 was assisting resident #008 with personal care, transferring to bed and bed mobility. After PSW #102 assisted transferring the

resident to the bed, resident #008 was observed to have sustained an identified number of injuries.

Inspector #672 reviewed the internal investigation notes into the incident, which indicated that PSW #102 had not followed the directions listed in resident #008's plan of care, specific to personal care, transfers and bed mobility, and had not utilized a specified mobility device during the transfer. The internal investigation notes further indicated a belief that while PSW #102 instructed resident #008 to utilize a specified type of personal assistive device during the transfer, the specified personal assistive device malfunctioned, possibly causing resident #008's injuries. Following the internal investigation the specified personal assistive device was replaced by a different type of personal assistive device.

Inspector #672 reviewed the CIR, and observed that the CIR had last been amended on a specified date, and stated the internal investigation revealed the allegation of improper/incompetent treatment of a resident was unfounded. The CIR did not list any information related to concerns with resident #008's personal assistive device possibly malfunctioning, which may have been the cause of the injuries, or that the specified personal assistive device was replaced by a different type of personal assistive device on a specified date, in an attempt to prevent a recurrence. The CIR was also not amended to include information related to the outcome and follow up specific to PSW #102.

During an interview, the DOC indicated the CIR was not amended after a specified date, and did not include information related to changing resident #008's specified personal assistive device to a different type of personal assistive device or the outcome and follow up specific to PSW #102. The DOC further indicated they were aware of the legislative requirement to update all written reports to the Director to include analysis and follow-up actions, including the immediate actions that were taken to prevent a recurrence, and the long-term actions planned to correct the situation and prevent a recurrence.

The licensee failed to ensure that the written report to the Director included the analysis, follow-up actions, and the long-term actions implemented in an attempt to correct the situation and prevent a recurrence. [s. 107. (4) 4.]

2. The licensee has failed to ensure that the written report to the Director included the long term actions that were taken to correct the situation and prevent a recurrence.

Related to Log #025002-18:

A Critical Incident Report was submitted to the Director on a specified date, related to an incident of resident to resident abuse between residents #012 and #013. According to the CIR, RN #121 observed residents #012 and #013 to be sitting in an identified area, displaying a responsive behaviour towards each other. Resident #013 made a movement which caused an identified injury to resident #012. Resident #013 did not sustain any injuries. According to the CIR, resident #012 was exhibiting with specified responsive behaviours, and a co-resident attempted to assist the resident in a specified manner. Resident #012 reacted by exhibiting further specified responsive behaviours. According to the CIR, resident #012 was exhibiting specified responsive behaviours, and a co-resident attempted to assist the resident in a specified manner. Resident #012 reacted by exhibiting further specified responsive behaviours. Under the long term actions section of the CIR, it was listed that resident #012 was on a waiting list for an identified intervention.

During review of resident #012's progress notes, Inspector #672 observed a note from a specified date which indicated that resident #012 received the identified intervention they had been on a waiting list to receive.

Inspector #672 reviewed the CIR and observed that the CIR had not been amended after a specified date, and did not include any information related to resident #012 receiving the identified intervention they had been on a waiting list to receive.

During an interview, the DOC indicated that resident #012 received the identified intervention they had been on a waiting list to receive. The DOC further indicated that the CIR was not amended after a specified date, and did not include information related to resident #012 receiving the identified intervention they had been on a waiting list to receive. The DOC indicated they were aware of the legislative requirement to update all written reports to the Director to include the long-term actions planned to correct the situation and prevent a recurrence.

The licensee failed to ensure that the written report to the Director included the long term actions taken in an attempt to correct the situation and prevent a recurrence, which included resident #012 receiving the identified intervention they had been on a waiting list to receive. [s. 107. (4) 4.]

3. The licensee failed to ensure that the written report to the Director included the analysis and follow-up action, including the immediate and long-term actions that were

taken to correct the situation and prevent a recurrence.

Related to Log #004691-19:

A Critical Incident Report was submitted to the Director on a specified date, related to an incident of resident to resident abuse which occurred between residents #010 and #011. The CIR indicated the incident resulted in resident #010 falling and resident #011 sustaining an identified injury. Resident #010 alleged that resident #011 had slammed a door and when resident #010 requested the door not be slammed, resident #011 immediately exhibited identified responsive behaviours, which led to resident #010 falling to the floor. Resident #011 alleged that resident #010 had approached the resident, and exhibited identified responsive behaviours. No injuries were noted on resident #010, and the residents were immediately separated.

Inspector #672 reviewed the internal investigation notes into the incident, which indicated the incident occurred as a result of resident #010 telling resident #011 not to slam the door, which led to both residents exhibiting identified responsive behaviours. This caused resident #010 to fall to the floor, with no injuries sustained and resident #011 sustained an identified injury during the incident. The investigation notes further indicated that on a specified date, a specified nursing intervention was added to resident #011's plan of care between specified hours of the day, and changes were made to resident #011's medication regime with effect pending. Resident #011 was moved from a specified area of the LTCH to another specified area on a specified date.

Inspector #672 reviewed the CIR and observed that the CIR had not been amended after a specified date, and did not include any information related to resident #011's medication changes, moving resident #011 from a specified area of the LTCH to another specified area, or the effectiveness of these changes.

During an interview, the DOC indicated that the CIR was not amended after a specified date, and did not include information related to moving resident #011 from a specified area of the LTCH to another specified area or related to the effectiveness of the medication changes made for resident #011. The DOC further indicated they were aware of the legislative requirement to update all written reports to the Director to include analysis and follow-up actions, including the immediate actions that were taken to prevent a recurrence, and the long-term actions planned to correct the situation and prevent a recurrence.

The licensee failed to ensure that the written report to the Director included the analysis and follow-up action, including the immediate and long term actions taken of moving resident #011 from a specified area of the LTCH to another specified area on a specified date or related to the medication regime changes made for resident #011, in an attempt to correct the situation and prevent a recurrence. [s. 107. (4) 4.]

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 each written report to the Director includes the analysis and follow-up action, including the immediate actions taken to prevent a recurrence, and the long-term actions planned to correct the situation and prevent a recurrence, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to the interventions were documented.

Related to Log #020292-18:

A Critical Incident Report was submitted to the Director on a specified date, related to an incident of improper/incompetent treatment of a resident, involving resident #008 and PSW #102. According to the CIR, PSW #102 was assisting resident #008 with personal care, transferring to bed and bed mobility. After PSW #102 assisted transferring the

resident to the bed, resident #008 was observed to have sustained an identified number of injuries.

Inspector #672 reviewed the progress notes from a specified time period, and observed a progress note from a specified date, which discussed concerns related to the worsening of the identified injuries, therefore resident #008 received a specified physician's order.

Inspector #672 reviewed the Physician's orders for resident #008, which indicated that resident #008 received a specified order on an identified date, to be utilized for an identified period of time. Inspector #672 also observed another physician's order for the identified injuries, on an identified date, to be utilized for an identified period of time.

Inspector #672 then reviewed the resident's medical records for a specified period of time, and found that there was no documentation related to resident #008's responses to the interventions, or an indication of when the identified injuries had improved. An identified assessment was completed on a specified date, and then another identified assessment was completed on a date one week later, which indicated the injuries were present, and provided a description of each injury. The next identified assessment was completed on a later specified date and did not contain a description of the injuries but indicated the resident's injuries were healing, and the treatment continued. Following that assessment, there were no other assessments, reassessments or progress notes completed which documented if/how the identified injuries were improving, or if the interventions were effective.

During separate interviews, RN #103, RPN #114, PSWs #102, #104 and #112, the RAI Coordinator and the DOC were all unable to determine when resident #008's identified injuries healed, or what resident #008's responses were to the interventions provided in an effort to promote healing, due to a lack of documentation.

During separate interviews, the RAI Coordinator and the DOC both indicated the expectation in the home was that the registered staff would document in a specified assessment and/or the progress notes the effectiveness of the interventions which were provided in an effort to promote healing of the identified injuries and the information should have been documented.

The licensee failed to ensure that any actions taken with respect to the identified injuries sustained by resident #008 on an identified date, under a required program, including assessments, reassessments, interventions and the resident's responses to the

interventions were documented. [s. 30. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that symptoms were recorded and that immediate action was taken as required on every shift.

Related to Log #020292-18:

A Critical Incident Report was submitted to the Director on a specified date, related to an incident of improper/incompetent treatment of a resident which resulted in harm or risk to a resident, involving resident #008 and PSW #102. According to the CIR, PSW #102 was assisting resident #008 with personal care, transferring to bed and bed mobility. After PSW #102 assisted transferring the resident to the bed, resident #008 was observed to have sustained an identified number of injuries.

Inspector #672 reviewed the resident's medical records for a specified period of time, which revealed that on a specified date and time, resident #008 was noted to be exhibiting identified symptoms and precautionary measures were put in place.

Inspector #672 reviewed the Physician's orders for resident #008, which indicated that resident #008 received a specified order on an identified date, to be utilized for an identified period of time.

Inspector #672 then reviewed the resident's medical records for a specified period of time, and noted there was no documentation related to resident #008's symptoms during the following shifts:

• During a specified date, from the evening shift
• During a specified date, from the night, day and evening shifts
• During a specified date, from the evening shift

During separate interviews, RPNs #114 and #119, and RN #103 all indicated that the expectation in the home was that while a resident was ill and receiving an identified type of physician's order, the resident was to be assessed and the information documented on during every shift.

During separate interviews, the RAI Coordinator and the DOC verified that the expectation in the home was that while a resident was symptomatic and receiving an identified type of physician's order, the resident was to be assessed and the information documented on during every shift.

The licensee failed to ensure that when resident #008 exhibited symptoms, that staff documented this information on every shift. [s. 229. (5) (b)]

Issued on this 6th day of May, 2019

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

Original report signed by the inspector.