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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 23, 2019	2019_715672_0003	029579-17, 019948-18, 025591-18, 032782-18	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

JENNIFER BATTEN (672)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 18, 20, 21, 22, 25, 2019

The following complaint logs were inspected during this inspection:

Log #025591-18 - related to resident to resident abuse and personal support services
Log #029579-17 - related to a medication incident, reporting and complaints, and pain management
Log #032782-18 - related to withholding approval for admission to the home
Log #019948-18 - related to skin and wound care, pain management, personal support services, nutrition care and hydration programs

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:
Admission and Discharge
Falls Prevention
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **2 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. (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).

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 the written plan of care set out clear directions to staff and others who provided direct care to the resident.

Related to Log #029579-17:

A complaint was received by the Director via phone call to the ACTIONLine, from resident #003's family member. The family member alleged that on a specified date, they were transporting the resident in an identified area of the LTC home using an identified mobility device, when an injury occurred. The resident was transferred to the hospital, and returned to the home with an identified injury and a treatment which was to be applied to the resident at all times. The complaint further indicated that the treatment was not applied properly on some occasions or not applied at all.

During a telephone interview, the complainant verified the information listed in the complaint from the ACTIONLine.

Review of resident #003's progress notes revealed that on a specified date, the complainant was transporting the resident in an identified area of the LTC home using an identified mobility device, when an injury occurred. The resident was transferred to the hospital for further assessment, and returned to the home with an identified injury and a treatment which was to be applied at all times.

Inspector #672 reviewed resident #003's written plan of care in place following the incident and did not find any information or direction to the staff that resident #003 had

sustained the identified injury, or information related to the ordered treatment. Inspector #672 further reviewed resident #003's medical records, including progress notes and did not observe any directions to the front line staff regarding resident #003's injury or treatment.

During an interview, the RAI Coordinator indicated that the expectation in the home was that the resident's plan of care was to be immediately updated to include the identified injury and ordered treatment.

The licensee failed to ensure that the plan of care for resident #003 set out clear directions to staff and others who provided direct care to the resident, related to an identified injury and ordered treatment. [s. 6. (1) (c)]

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

Related to Log #025631-18:

A Critical Incident Report was submitted to the Director related to an incident of alleged resident to resident abuse which occurred between residents #005 and #006. According to the CIR, at an identified time, staff were called to an identified area, due to resident #006 entering the identified area and initiating the alleged incident.

Related to Log #025591-18:

A complaint was also received by the Director related to the allegation of resident to resident abuse between residents #005 and #006, from resident #005's Substitute Decision Maker (SDM). The complaint indicated that resident #005 reported resident #006 had wandered into an identified resident area at an identified time, and initiated the alleged incident which involved resident #005. The complaint further indicated that resident #005 physically struggled with resident #006 for a short period of time before staff responded to the call bell and arrived to remove resident #006. The staff did not return to check on resident #005, or request a statement of what had occurred.

During an interview, the complainant indicated that as a result of the alleged incident of resident to resident abuse, resident #005 was no longer comfortable with receiving an identified activity of daily living if not provided by an identified type of staff member, which had resulted in resident #005 missing an identified amount of the identified activity of

daily living in the previous few weeks. The complainant further indicated that this concern had been reported to the nursing staff, DOC and Administrator, but had not been rectified.

During an interview, resident #005 verified that as a result of the alleged incident of resident to resident abuse, they were no longer comfortable with receiving an identified activity of daily living from an identified type of staff member, which had resulted in missing the identified activity of daily living in the previous few weeks. Resident #005 further indicated that this concern had been reported to the nursing staff, DOC and Administrator, but had not been rectified.

Inspector #672 reviewed resident #005's written plan of care, which indicated that resident #005 was to receive an identified activity of daily living a specified number of times per week, and the identified activity of daily living was not to be provided by an identified type of staff member.

Inspector #672 reviewed the documentation during a specified period of time, related to resident #005's activity of daily living schedule. The report indicated that resident #005 did not wish to have an identified activity of daily living provided by an identified type of staff member. During a specified period of time, resident #005 received an identified activity of daily living a specified number of times during an identified period of time. The documentation during a later specified period of time revealed that resident #005 did not receive an identified activity of daily living as follows:

On nine specified dates, resident #005 refused to have the identified activity of daily living. There was an identified type of staff member scheduled to complete the identified activity of daily living on each of those dates. On two specified dates, resident #005 received the identified activity of daily living, which was provided by an identified type of staff member that resident #005 did not wish to have assist them. Resident #005 did not receive the identified activity of daily living again until one week later. During a later specified period of time, resident #005 did not receive the identified activity of daily living.

Review of the progress notes revealed that resident #005 refused the identified activity of daily living on a specified date, due to an undocumented reason, but indicated that resident had gone on LOA that day. There was no alternate identified activity of daily living documented after the refusal on the specified date.

During an interview, the RAI Coordinator indicated being aware that resident #005

frequently refused the identified activity of daily living. The RAI Coordinator further indicated that the expectation in the home was that if an identified type of staff member was on duty assisting with the identified activity of daily living, and a resident did not wish assistance from that type of staff member, the identified activity of daily living should be provided by another staff member. The RAI Coordinator indicated that if a resident was refusing the identified activity of daily living for a specified reason, the resident should be offered a "make up" later that day or the following day. The RAI Coordinator further indicated it would be the responsibility of both the resident and the staff to monitor if a resident had refused and required the identified activity of daily living to be provided on an alternate day. If the resident did not speak up and request an alternate, they may not receive one.

During separate interviews, the DOC and Administrator indicated being aware that resident #005 had been refusing the identified activity of daily living due to a concern with having an identified type of staff member providing the assistance. The DOC indicated working with the resident, to ensure they received a specified number of the identified activity of daily living from an identified type of staff member.

The licensee failed to ensure that the care set out in resident #005's plan of care was provided to the resident as specified in the plan, by not ensuring the resident received a specified number of an identified activity of daily living per week; and by not ensuring the resident did not receive the identified activity of daily living from an identified type of staff member. [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 each resident's plan of care set out clear directions to staff and others who provided direct care to the resident when the resident's care needs change, and to ensure that the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

Related to Log #029579-17:

A written complaint was received by the licensee from resident #003's family member, regarding a medication incident, involving residents #003 and #014. The Physician assessed the resident, and a decision was made to transfer resident #003 to the hospital for further assessment. Agency RPN #118 indicated that a medication error had occurred earlier that morning. The decision was made not to transfer resident #003 to hospital, but to monitor the resident's condition in the home instead. The licensee forwarded a copy of the written complaint to the Director, along with a copy of the written response.

During a telephone interview, the family member of resident #003 verified the information listed in the complaint.

Inspector #672 reviewed the medication incident report, which indicated that on a specified date, Agency RPN #118 was working in the home, administering medications, but was unfamiliar with the residents. The report indicated that a medication incident had occurred on a specified date.

Agency RPN #118 was not available for interview during this inspection.

Inspector #672 reviewed the electronic Medication Administration Record (eMAR), and found that each resident eMAR was accompanied by a picture of the resident.

Inspector #672 then reviewed resident #003's medical records. Following the medication incident, resident #003 displayed a change in condition and was assessed by the Nurse Practitioner.

During an interview, the DOC indicated that the expectation in the home was for all Registered staff administering medications to follow the best practice guidelines when administering medications.

The licensee failed to ensure that medications were administered to resident #003 as prescribed. [s. 131. (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 that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse that the licensee knew of, or that was reported was immediately investigated.

Related to Log #025631-18:

A Critical Incident Report was submitted to the Director on a specified date, related to an incident of alleged resident to resident abuse which occurred between residents #005 and #006. According to the CIR, at a specified time, staff were alerted that resident #006 was involved in an incident of resident to resident abuse towards resident #005.

Related to Log #025591-18:

A complaint was also received by the Director related to the allegation of resident to resident abuse between residents #005 and #006, from resident #005's Substitute Decision Maker (SDM). The complaint indicated that resident #005 reported that on a specified date and time, resident #006 initiated the incident of resident to resident abuse. The complaint further indicated that during the incident there was a delay in staff responding to resident #005's call bell. The staff did not return to check on resident #005, or request a statement of what had occurred.

Review of resident #006's written plan of care in place at the time of the incident revealed that the resident had a history of identified responsive behaviours.

During an interview, resident #005 indicated that on a specified date and time, resident #006 initiated the incident of resident to resident abuse. The resident further indicated there was a delay in staff response to the call bell. Resident #005 indicated that a PSW removed resident #006, but did not return to check on resident #005 or take a statement. The resident was not interviewed about the incident by the Director of Care until several days after the occurrence.

Inspector #672 then reviewed the internal investigation package, and noted that resident #005's statement was obtained on a specified number of days after the incident, and the first staff statement was obtained on a specified number of days after the incident.

During an interview, the DOC indicated they first became aware of the alleged incident on the morning the incident had occurred, when reading the shift report notes, but was unable to begin the internal investigation until a number of days later, due to staff schedules and coordination with union representatives. The DOC further indicated being aware that internal investigations were to be commenced immediately upon becoming aware of the allegation of incidents of resident to resident abuse.

The licensee failed to ensure that an allegation of resident to resident abuse between residents #005 and #006 was immediately investigated. [s. 23. (1) (a)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. Under the LTCHA, 2007, s. 44(7) the appropriate placement coordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43(6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless, (a) the home lacks the physical facilities necessary to meet the applicant's care requirements; (b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or (c) circumstances exist which are provided for in the regulations as being a ground for withholding approval.

Related to Log #032782-18:

A complaint was received by the Director indicating an applicant had been refused

admission to the Long-Term Care Home.

Review of the applicant's refusal letter for admission from the licensee indicated the applicant was refused admission due to identified reasons.

The explanation provided by the licensee in the refusal letter was that the home lacked an identified intervention, required due to an identified responsive behaviour the Director of Care indicated the applicant exhibited. The letter further indicated they were concerned about the applicant's safety based on the information presented to them in the LHIN application for placement, specifically related to three identified responsive behaviours.

Review of the Placement Services Behavioural Assessment Tool indicated that the applicant did not have an identified responsive behaviour, but did exhibit one incident on a specified date, which was purposeful. The Placement Services Behavioural Assessment Tool indicated that the applicant did not have another identified responsive behaviour the refusal letter had outlined, however the applicant did have one incident more than two years prior, which the applicant was able to be immediately redirected from. Regarding a third identified responsive behaviour outlined in the refusal letter, the assessment tool indicated that the applicant "occasionally" exhibited the behaviour, but the assessment tool further indicated that this may have been due to legitimate concerns. Related to the applicant's fourth identified responsive behaviour outlined in the refusal letter, the assessment indicated that the applicant required interventions totaling less than 30 minutes over a 24 hour period.

In an interview with Inspector #672, the Director of Care of Ballycliffe Lodge LTCH, indicated that the LTCH did have a Behavioural Supports Ontario (BSO) team in the home consisting of one Registered Practical Nurse and one Personal Support Worker; that the nursing staff did have experience in managing responsive behaviours and had completed education related to Gentle Persuasive Approach (GPA), but felt that the applicant's assessment indicated that the applicant exhibited identified responsive behaviours which they felt could only be managed through an identified intervention. The Director of Care declined the application because the LTCH did not have the identified intervention.

The documented evidence provided by the licensee did not support how the home lacked the nursing expertise or physical facilities necessary to meet the applicant's care requirements, or how the applicant's care needs were outside of the nursing expertise

offered in the home. [s. 44. (7)]

2. The licensee has failed to ensure that when withholding approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out, the ground or grounds on which the licensee is withholding approval; a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; an explanation of how the supporting facts justify the decision to withhold approval; and contact information for the Director. 2007, c. 8, s. 44 (9).

Related to Log #032782-18:

This inspection was initiated related to a complaint received by the Ministry of Health and Long Term Care, submitted by an identified entity, related to applicant #007. The complaint pertained to withholding approval for admission to Chartwell Ballycliffe Lodge LTC Home.

A review of applicant #007's application and the Placement Services Behavioural Assessment Tool completed by the Central East LHIN identified that this applicant was living at a group home in the community, and required placement in to a Long Term Care Home (LTCH).

An application for admission was made to the LTC home. A letter from the Director of Care on behalf of Chartwell Ballycliffe Lodge LTC Home addressed to the applicant stated the following details for withholding approval for admission:

"Thank you for your application to Ballycliffe Lodge Long Term Care. Unfortunately we are withholding approval of your admission at this time because we do not have the necessary resources to meet your needs. This means that:

1. Our home lacks the nursing expertise necessary to meet your care requirements.
2. Our home lacks the physical facilities necessary to meet your care requirements.
3. Our home cannot provide the care you need because at the present time your care needs would be more than we would be able to effectively manage.

We have carefully evaluated the assessments provided with your application and as per information from the Central East LHIN, your (identified responsive behaviours) indicates a Home with the necessary physical facilities is more appropriate for your current care

needs. Therefore, Ballycliffe cannot accept your application."

During an interview with the Director of Care, they confirmed the reasons the application for admission was denied.

The letter did not provide for a detailed explanation of the supporting facts, or how the supporting facts justified the decision to withhold approval. [s. 44. (9)]

WN #5: 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 has failed to ensure that a documented record was kept in the home that included:
(a) the nature of each verbal or written complaint, (b) the date the complaint was received, (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, (d) the final resolution, if any, (e) every date on which any response was provided to the complainant and a description of the response, and (f) any response made by the complainant.

Related to Log #029579-17:

A written complaint was received by the licensee from resident #003's family member, related to a medication incident involving residents #003 and #014.

During a telephone interview, the complainant verified the information listed in the complaint.

Inspector #672 then requested a copy of the licensee's internal complaints log from a specified time period. The Administrator indicated there were only complaints received during that time frame in one of the identified months, which included two complaints from resident #003's family member, one of which was outlined in the complaint in Log #029579-17. Inspector #672 then reviewed the complaints log, and observed that the complaint was missing some part of the documentation required under the legislation, as follows:

The complaint received on a specified date, was missing documentation related to 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; the final resolution, if any; and a description of the response provided to the complainant.

During an interview, the Administrator indicated being aware of the documentation requirements under the legislation, related to both verbal and written complaints.

The licensee failed to ensure that a documented record was kept in the home, which included all of the required documentation under the legislation, specific to 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; the final resolution, if any; and a description of the response provided to the complainant. [s. 101. (2)]

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.