Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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

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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
Sep 6, 2019	2019_716554_0003	032422-18, 001691-19, 002631-19, 002729-19	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 Bon Air Long Term Care Residence
131 Laidlaw Street South Cannington ON L0E 1E0

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 Complaint inspection.

This inspection was conducted on the following date(s): July 29, 30 and July 31; August 01, 02, 07, 08, and August 09, 2019

The following intakes were inspected:
#032422-18 - related to alleged staff to resident abuse
#001691-19, #002631-19 and #002729-19 - related to air temperatures in the long-term care home and shortage of laundry supplies

Report #2019_716554_0002 - similar non-compliance was identified related resident #012 pursuant to LTCHA, 2007, s. 6 (7) plan of care; and similar non-compliance was identified related to resident #001 and resident #012 pursuant to s.24. (1) - immediate reporting. These non-compliances will be reflected in this report as the inspections were completed concurrently.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Workers (PSW), Housekeepers, a Laundry Aide, Registered Dietician, residents and families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **7 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 failed to provide care to residents as set out in the plan of care.

Related to Log #032422-18:

The Administrator submitted a Critical Incident Report (CIR) to the Director on an identified date. The CIR was regarding an alleged abuse of resident #003. The alleged abuse involved identified staff. The alleged abuse incident involved how resident #003 was administered an identified medication.

The plan of care for resident #003 was reviewed by Inspector #554 during this inspection. The review indicated special instructions regarding medication administration for resident #003, identified responsive behaviours and related triggers and interventions specific to resident #003.

RPN #103 indicated to Inspector #554 being assigned to administer resident identified medications to residents on an identified date. RPN indicated administering the identified medication to resident #003 on the identified date. RPN #103 indicated that resident #003 was exhibiting an identified responsive behaviour while the identified medication was being administered. RPN indicated telling the DOC that resident #003 was exhibiting an identified responsive behaviour, RPN #103 indicated that the DOC offered assistance to administer the medication. RPN #103 indicated the DOC entered the room, assisted with resident #003 but resident continued to exhibit the identified responsive behaviour. RPN indicated it was at that point that the DOC decided to get a third person to assist with the medication administration to resident #003.

PSW #104 indicated to Inspector #554 being present when resident #003 was being administered an identified medication. PSW indicated being called into the resident's room by the DOC; PSW indicated that RPN #103 was present. PSW #104 indicated that resident #003 was exhibiting identified responsive behaviours. PSW described how they held resident #003 while the medication was being administered. PSW indicated that resident #003 continued to exhibit the identified responsive behaviour until the medication was administered and staff left the room.

The DOC indicated to Inspector #554 being present on the identified date when resident #003 was being administered the identified medication. DOC indicated being told that resident had refused the medication to be administered, DOC indicated offering to assist RPN #103. The DOC indicated that resident #003 continued to be exhibit an identified responsive behaviour, so a third staff was called into resident #003's room to assist. The DOC indicated that the third staff was PSW #104. The DOC described the manner in

which resident was held to administer the identified medication. The DOC indicated that the medication was administered despite resident #003 exhibiting an identified responsive behaviour.

PSW #104, RPN #103 and the DOC indicated being aware of the plan of care for resident #003. All three indicated being aware that resident exhibited specific responsive behaviours. PSW #104, RPN #103 and the DOC indicated that the planned intervention when resident exhibiting responsive behaviours was to leave the resident 10-15 minutes and reapproach. RPN #103 indicated that resident was not left 10-15 minutes and reapproached on the identified date prior to advising the DOC of medication refusal, nor was the resident left alone 10-15 minutes and reapproached prior to the DOC calling PSW #104 to assist. RPN #103 and the DOC indicated being aware of the special instructions regarding medication administration for resident #003.

The Administrator indicated to Inspector #554 that staff are to provide care to each resident based on their plan of care.

The PSW #104, RPN #103 and the DOC failed to provide care to resident #003 as set out in the plan of care. [s. 6. (7)]

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.

Non-compliance identified from report #2019_716554_0002 related to resident #012 is reflected in this report as the inspections were completed concurrently.

Related to Resident #012:

Non-Compliance was identified while inspecting Log #004825-18, scope was expanded to include resident #012 who was known by nursing staff and the Administrator to exhibit responsive behaviours.

PSW #114, RPN #103, RPN #105 and the DOC indicated to Inspector #554 that resident #012 is known to exhibit identified responsive behaviours. PSW #114 and RPN #103 and RPN #105 indicated that there are some residents who area affected resident #012 exhibited responsive behaviours.

A review of the physician's orders for resident #012 by Inspector #554 indicated that

specific staffing was ordered on an identified date.

PSW #114, RPN #105 and RN #117 indicated to Inspector #554 being aware of the identified staffing order for resident #012. RPN #105 indicated that the physician's order dated on an identified for specific staffing was a current order by resident #012's attending physician.

PSW #114, RPN #105 and RN #117 indicated that as of this time, management only has the ordered staffing in place for resident during identified hours but indicated that the ordered staffing is inconsistent due to staffing shortages with the contracted service provider hired and further indicated there has been times when there was no ordered staffing available for resident #012. RPN #105 and RN #117 indicated that if there is no assigned staff available for resident #012, the nursing staff working on the floor try to monitor resident #012's whereabouts but indicated it was difficult to monitor the resident while attending to the care needs of the other residents.

The DOC and the Administrator indicated to Inspector #554 being aware of the physician's order related to specific staffing for resident #012. The DOC indicated that the purpose of the identified staffing was to prevent resident #012 from exhibiting identified responsive behaviours towards other residents.

The DOC and the Administrator indicated that the licensee does not utilize their own employees for the ordered staffing needs due to lack of available staff. The Administrator indicated a contracted service provider is contracted for the ordered staffing and that the licensee utilizes a contracted service provider for this purpose. The Administrator provided Inspector #554 with invoices from identified contracted service provider for ordered staffing for resident #012 during identified dates this year.

Inspector #554 reviewed documented dates and times that the ordered staffing had been in place through the contracted service provider.

The Administrator indicated being unaware of dates that the contracted service provider was utilized during the last three weeks, indicating they rely on invoices for dates that service was utilized. The Administrator indicated having no invoices for the past three weeks.

The DOC and the Administrator indicated that ordered staffing was provided inconsistently to resident #012 during the identified months as the agency service

provider was unable to consistently provide a PSW for the ordered staffing. The Administrator indicated that no other agency service provider had been contracted to assist in the ordered staffing. The Administrator indicated that the attending physician had not been advised that the ordered staffing order was not being followed.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #012 as specified in the plan, specifically a physician's order for the identified staffing. [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 ensuring that the care set out in the plan of care is provided as specified in the plan, to be implemented voluntarily.

WN #2: 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 was complied with.

The licensee's policy, Abuse Allegations and Follow-Up states that Chartwell Residences are abuse free environments/communities. The policy directs that all staff must immediately report the suspicion and information that it is based on to Director. The policy further directs that all employees are required to, as a component of the Chartwell's internal reporting structure to ensure safety for all, report immediately to their respective supervisor/person in charge of the building when abuse is alleged, suspected

or witnessed.

Related to Log #032422-18:

The Administrator submitted a CIR to the Director on an identified date this year. The CIR was regarding an alleged abuse of resident #003. The alleged abuse involved identified staff. The alleged abuse incident involved how resident #003 was administered a identified medication.

RN #106, who is a Charge Nurse, indicated to Inspector #554 awareness of the alleged staff to resident abuse incident involving resident #003. RN indicated being told of the incident by RPN #105 on an identified date. RN indicated awareness of the licensee's zero tolerance of abuse policies and indicated that incidents of alleged, suspected or witnessed abuse are to be immediately reported to the DOC or Administrator.

RN #106 indicated not reporting the incident to the DOC for identified reasons. RN #106 indicated not advising the Administrator of the alleged incident. RN #106 indicated advising the staff who had reported the alleged incident to contact the Ministry of Health and Long-Term Care by using the Action Line. RN #106 indicated taking no further action specific to the alleged abuse of resident #003.

The Administrator indicated to Inspector #554 that all staff are to abide by the licensee's policy's specific to zero tolerance of abuse. The Administrator indicated allegations of abuse are to be reported immediately by staff to the Charge Nurse, and the Charge Nurse is to immediately report allegations, suspected or witnessed abuse to the DOC or the Administrator.

The licensee, specifically RN #106 failed to comply with the licensee zero tolerance of abuse policy by not reporting the alleged abuse of resident #003 to the Administrator. [s. 20. (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 ensuring that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written hot weather-related illness prevention and management plan was implemented.

The licensee's policy, Extreme Heat and Cold Weather Precautions states that the policy provides staff with direction for monitoring and maintaining air temperature and humidex of the environment and guidance to direct care during periods of hot weather and extreme cold.The policy directs the following:

Extreme Hot Weather:
- The Environmental Service Manager (ESM) or delegate will install two hygrometers in each home area, one to be located in a perceived hot spot and one to be installed in the largest designated cooling area.
- The ESM or delegate will monitor and document the air temperature and humidex during hot weather months (May 01 to September 30)
- If humidex level exceeds 30 percent (%), the ESM or delegate will alert the home to

implement the Hot Weather Protocols.
- If HVAC system failure, ESM or delegate will refer to the Emergency Plan and Maintenance manual for further direction.

Extreme Cold Weather:
- The residence will be monitored, and appropriate measures taken to ensure the home is maintained at a minimum temperature.
- The ESM or delegate will monitor and document the air temperature in two areas of the home daily.
- If the air temperature is less than 22 C, heating is to be adjusted and measures taken to ensure the comfort and warmth of residents until appropriate temperature is retained.
- If HVAC system failure, ESM or delegate will refer to the Emergency Plan and Maintenance manual for further direction.

The Inside Air Temperature Sheet, which is part of the Extreme Heat and Cold Weather Precautions policy and procedures directs that:
- Should the temperature not be in the acceptable range you must inform the Administrator or Director of Care or the manager on call, who is responsible for taking immediate corrective action. Note action taken on the sheet (Inside Air Temperature Sheet). Temperatures must be taken at the start and end of the day.

Related to Logs #001691-19, #002631-19 and #002729-19:

The Director received three anonymous complaints regarding the Air Temperature in the long-term care home during identified dates this year.

RN #106, #111 and RN #117 indicated to Inspector #554 that air temperatures, as of a specific date, are taken and documented twice daily by the RN. The RN's indicated that prior to the identified date the maintenance staff use to take and document the air temperatures in the LTCH. The RN's indicated that concerns regarding the air temperatures in the home are reported to the Administrator in morning report or throughout the shift.

RPN #105 and RN #106 indicated to Inspector #554 that the RN takes the air temperature twice daily and records the air temperature in a binder which is kept in the medication room. The air temperature binder was provided for review to Inspector #554.

Chartwell Bon Air Inside Temperature Sheets were reviewed for a specified period which

identified dates when the air temperature as less than the minimum requirement of 22 C and there was no documentation that the heating was adjusted and or measures taken to ensure the comfort and warmth of residents until appropriate air temperature was retained. During this same review, there were dates when no air temperature was taken in the home, documentation when no humidex was documented and dates where the humidex was documented to be greater than 30%, and no documentation as to the actions taken by the ESM or delegate.

At the time of this inspection Chartwell Bon Air Long-Term Care Residence did not have an ESM employed or maintenance staff. The Administrator oversee's Accommodation Services, which includes maintenance services in the home. The Administrator indicated that the maintenance staff's role included air temperature monitoring until an identified date and since that time the RN is to monitor air temperatures in the home.

The maintenance staff were unavailable for an interview during this inspection.

The Administrator indicated to Inspector #554 being aware that there had been a few dates in 2019 when the air temperature in the home was not maintained at 22 C but could not recall exactly which dates they were but indicated that a contracted service provider had been called for repair of the HVAC system on four identified dates. The Administrator indicated being unaware if air temperatures were taken in an identified months and indicated having no documentation of twice daily air temperatures during that identified month. The Administrator indicated being unaware that that the humidex was not being taken or recorded during a two month period. The Administrator indicated being unaware that the ESM or delegate had not taken temperatures daily during the specific dates nor documented action taken when temperatures in the home were not at a minimum of 22 C or when the humidex exceeded 30%.

The licensee failed to ensure that the written hot weather-related illness prevention and management plan was implemented and complied with. [s. 20. (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 ensuring there is a written hot weather-related illness prevention and management plan and that the plan is implemented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee has failed to ensure the home is maintained at a minimum of 22 degrees Celsius.

Related to Logs #001691-19, #002631-19 and #002729-19:

The Director received three anonymous complaints regarding the Air Temperature in the long-term care home during an identified period, specifically during two specific months.

RPN #105 indicated to Inspector #554 that the RN takes the air temperature twice daily and records the air temperature in a binder which is kept in the medication room. The air temperature binder was provided for review to Inspector #554.

Chartwell Bon Air Inside Air Temperature Sheets were reviewed for a specified period. The review documented that during specific dates air temperatures were not maintained at 22 C. Documentation is inconsistent as to actions taken when air temp was less than 22 C. The Administration was unable to locate air temperatures for one month during the identified period.

RN #106, #111 and RN #117 indicated to Inspector #554 that air temperatures were taken and documented twice daily by the RN. The RN's indicated that prior to an identified date the maintenance staff use to take and document the air temperatures in

the LTCH. The RN's indicated that concerns regarding the air temperatures in the home are reported to the Administrator in morning report or throughout the shift.

A PSW (#109) indicated to Inspector #554 that air temperatures in the LTCH during the winter, specifically during two months, were inconsistently maintained at 22 C. The PSW indicated that on an identified date, the LTCH was cold and indicated that residents and staff were complaining of being cold.

An RN (#106) indicated that the LTCH was cold on identified date and indicated that residents and staff had complained of being cold. The RN indicated that the thermometer in an identified resident hall was observed to be 18 C on the identified date. The RN indicated that residents also complained of the dining room being cold; RN indicated a thermometer was placed in the room by staff and indicated that the thermometer was observed to be 19 C. The RN indicated that the air temperature in the home were reported to the Administrator.

Resident #013 and resident #015 indicated to Inspector #554 that the LTCH had been cold this past winter. Resident #015 indicated complaining to staff about the cold and indicated that the staff member replied that the windows were old and that new ones had been ordered. Resident #015 indicated voicing no further concern regarding the air temperature in the LTCH after the initial complaint. Resident #015 could not recall date of the complaint.

The Administrator indicated to Inspector #554 being aware that there had been a few dates in 2019 when the air temperature in the home was not maintained at 22 C but could not recall exactly which dates they were. The Administrator indicated being aware of air temperature issues on four specific dates but indicated no awareness of air temperature issues on the other above dates.

The licensee failed to ensure that the home is maintained at a minimum of 22 degrees Celsius. [s. 21.]

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 ensuring the home is maintained at a minimum of 22 degrees Celsius, to be implemented voluntarily.

WN #5: 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 has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Pursuant to O. Reg. 79/10, s. 2 (1) – For the purposes of the definition of abuse in subsection 2 (1) of the Act,

Emotional abuse means – any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gesture, actions, behaviour or remarks understands and appreciates their

consequences.

Physical abuse means:
- the use of physical force by anyone other than a resident that causes physical injury or pain;
- the use of physical force by a resident that causes physical injury to another resident.

Verbal abuse means:
- any form of verbal communication of a threatening or intimidating nature by a resident that leads another resident to fear for their safety where the resident making the communication understands and appreciates its consequences.

Related to Log #032422-18:

The Administrator submitted a CIR to the Director on an identified date. The CIR was regarding an alleged abuse of resident #003. The alleged abuse involved identified staff. The alleged abuse incident involved how resident #003 was administered an identified medication.

The Director of Care indicated to Inspector #554 that resident #003 received the identified medication on an identified date last year.

RN #106, who is a Charge Nurse, indicated to Inspector #554 awareness of the alleged abuse incident involving resident #003. RN indicated the alleged incident occurred on an identified date; RN indicated awareness of the incident on the same date as the alleged incident. RN indicated being told of the incident by RPN #105. RN indicated the incident was not reported to the Director. RN #106 indicated awareness of the reporting requirements, and indicated that the incident was not reported to the Director for a specific reason, and indicated the reason.

The Administrator indicated being unaware of the alleged abuse of resident #003 by staff until an identified date. The Administrator indicated that all registered nursing staff are aware that alleged, suspected or witnessed abuse of a resident is to be immediately reported to the Director. The Administrator indicated the alleged abuse of resident #003 by staff was not reported to the Director until an identified date this year. The incident allegedly occurred on last year.

The Administrator indicated that Charge Nurse-RN #106 should have reported the

incident to the Director.

The licensee, specifically Charge Nurse-RN #106 failed to ensure that the alleged abuse of resident #003 by staff had was immediately reported to the Director. [s. 24. (1)]

2. Related to Log #004825-18:

Non-compliance identified from report #2019_716554_0002 related to resident #001 and resident #012 is reflected in this report as the inspections were completed concurrently.

The Director of Care submitted a CIR on an identified date regarding resident to resident physical abuse of resident #002 by resident #001.

A review of the progress notes for resident #001 an identified period by Inspector #554 indicated specific incidents were resident #001 exhibited identified responsive behavours towards other residents prior to the CIR, including towards resident #002.

PSW #109, RPN #105 and RN #106 indicated to Inspector #554 during interviews, that resident #001 was aware of their actions. PSW, RPN and the RN indicated that resident #001 seemed to target residents #002, #017 and resident #016. All three staff indicated that resident #001's actions affected other residents. RPN #105 and RN #106 indicated that the DOC and the Administrator were aware of the witnessed abuse of residents by resident #001.

RN #106 indicated that staff concerns regarding resident to resident abuse by resident #001 towards other residents was communicated to the DOC, the Administrator and other managers on various dates. RN #106 indicated specifically communicating an identified incident between resident #001 and resident #016, and an identified incident between resident #001 and resident #002 to the Administrator and the DOC.

The DOC indicated to Inspector #554 being aware of the reporting requirements. The DOC indicated being aware of the documented and witnessed abuse incidents involving resident #001 towards residents #002, #016 and resident #017 through review of daily health records and through communications by registered nursing staff and or others in daily report. The DOC indicated that the incidents were not reported to the Director as resident #001 had an identified CPS. The DOC indicated that alleged, suspected or witnessed abuse of residents towards other residents are not reported to the Director if the resident has a CPS of three or greater and there is no physical injury. The DOC

indicated being unsure if this is written within the licensee's zero tolerance of abuse policies but indicated that it has been the practice.

The Administrator indicated to Inspector #554 that incidents where resident #001 was verbally abusive to other residents should have been reported to the Director.

The licensee failed to ensure that alleged, suspected or witness abuse of resident #002, #016 and resident #017 by resident #001 was immediately reported to the Director. [s. 24. (1) 2.]

3. Related to resident #012:

During the inspection of Intake #004825-18, non-compliance was identified pursuant to Section 24 and therefore the scope was expanded to include resident #012.

The Director of Care submitted a CIR on an identified date related to an alleged abuse by resident #012 towards resident #018. The incident resulted in physical injury to resident #018.

A review of the progress notes for resident #012 for a specific date by Inspector #554 indicated that resident #012 exhibited an identified responsive behaviour towards resident #019.This incident was witnessed by a co-resident.

A review of the progress notes for resident #019 for the identified date by Inspector #554 indicated the following:
Resident #012 exhibited an identified responsive behaviour towards resident #012.
Resident #019 was assessed by registered nursing staff to have injury.

The DOC indicated to Inspector #554 being aware of the documented and witnessed abuse incident involving resident #012 towards resident #019 through review of daily progress notes and through communications by registered nursing staff and or others in daily report. The DOC indicated that the incident was not reported to the Director as it was understood that resident #019 had not been injured.

The Administrator indicated to Inspector #554 that incident involving resident #012 towards resident #019 should have been reported to the Director as the assessment for resident #019 identified injury to resident #019.

The licensee failed to ensure that alleged, suspected or witness abuse of resident #019 by resident #012 was immediately reported to the Director. [s. 24. (1) 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 ensuring that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director; Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure there was a sufficient supply of clean linens, face cloths and bath towels always available the home for use by the residents.

Related to Logs #001691-19, #002631-19, and #002729-19:

The Director received anonymous complaints regarding shortages of linens in the long-term care during specific months this year.

The Chartwell Laundry Service Guidebook indicates that Laundry Department or service provided at each Chartwell community needs to be efficient and meet the needs of both

the residents and staff. The Laundry Service Guidebook directs that a a linen inventory count will be completed on a quarterly basis each calendar year and further states that linen quotas/requirements will be completed on a quarterly basis or more frequently as required using the Daily Linen Requirement Form.

Chartwell Bon Air Long-Term Care Residence has 54 residing residents and one short stay bed.

PSW #109, PSW #114, RPN #105 and RN #106 indicated to Inspector #554 during interviews that the home is frequently short identified linens. PSWs and registered nursing staff indicated that often they come on shift to find they have only one face cloth and one hand towel for care, staff indicated that this is not sufficient for the care of the residents. A registered nursing staff indicated that the linen room is often empty of linens when they arrive on shift and indicated that clean linens do not arrive to the RHA until a specific hour or later. A PSW indicated that on an identified date they had only two bath towels available for bathing residents. A PSW indicated that on an identified date three to four resident's beds went without making as they did not have identified linens available available. All staff interviewed indicated that linens shortages have been occurring for a long time but indicated that it has worsened this year. PSW's and registered nursing staff indicated that they have voiced their concerns to the DOC, the Administrator and other managers on more than one occasion but specifically have voiced concerns during dates this year.

Observations of available linens on linen carts and in linen rooms were observed and documented by Inspector #554 during this inspection.

PSWs indicated that they are permitted one face cloth and one hand towel per resident for morning and bedtime care. PSW's indicated that they cannot properly provide care to residents without adequate linens.

The DOC indicated to Inspector #554 being aware that staff had concerns regarding linen shortages and indicated that the Administrator looked after linen supplies in the home.

Laundry Aide (LDY) #113 indicated to Inspector #554 that they wash, dry and distribute linens that have been sent down from the resident home area (RHA) for laundering. LDY #113-indicated they wash, dry and distribute linens to the RHA linen room daily at a specific hour. LDY #113 indicated that there is no specific quantity of linens taken up to

the RHA, indicating that they wash and dry what linens have been sent down and return that quantity back to the linen room. LDY indicated there is no process around ensuring adequate quantities of linens are available for use by staff for resident care.

The Administrator indicated to Inspector #554 being aware that there had been concerns from staff regarding linen shortages in the home. The Administrator indicated putting out specific linens and indicated that the supplies disappears; the Administrator indicated saying to the staff that they needed to find where the linens went before more linens for use. The Administrator indicated awareness that there were not enough linens in the RHA on a specific date indicating that laundry staff scheduled had gone home at a specific hour without replacement. The Administrator indicated that there is one laundry staff and that they work specific scheduled hours during the day.

During a second interview, the Administrator indicated speaking to the Chartwell Environmental Consultant. The Administer indicated being directed to review a document called 'Linen Category and Inventory Levels', the Administrator indicated that this is a guideline that Chartwell homes were to follow to ensure there is an adequate supply of linens available. The Administrator indicated that according to this document there was not enough linens available in the home for resident care. The Administrator indicated that more linens would be put out and that a purchase order would be placed to ensure adequate linens were available for use and as a back up supply. The Administrator indicated that the linen inventory count and the linen quotas/requirements have not been completed quarterly.

The licensee has failed to ensure there was a sufficient supply of clean linen always available the home for use by the residents. [s. 89. (1) (b)]

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 ensuring there was is a sufficient supply of clean linens, face cloths and bath towels always available the home for use by the residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #003's SDM was notified within twelve hours of becoming aware of any alleged abuse of the resident.

Related to Log #032422-18:

The Administrator submitted a CIR to the Director on an identified date this year. The CIR was regarding an alleged abuse of resident #003. The alleged abuse involving identified staff. The alleged abuse incident involved how resident #003 was administered an identified medication.

The Director of Care indicated to Inspector #554 that resident #003 received the identified medication on on an identified date last year.

The plan of care for resident #003 was reviewed by Inspector #554. There was no documentation specific as to an allegation of abuse on an identified date.

RPN #105 and RN #106, who is a Charge Nurse, indicated to Inspector #554 awareness of the alleged abuse incident involving resident #003 on the day the alleged incident had occurred. RPN and the RN indicated they had not notified resident's SDM of the alleged abuse.

The Administrator indicated to Inspector #554 that registered nursing staff are to notify a resident's SDM of any alleged, suspected or witnessed abuse the same day as the incident occurs. The Administrator indicated not knowing of this allegation until an identified date.

The licensee failed to ensure that the resident's SDM was notified within twelve hours of an alleged abuse incident involving resident #003. [s. 97. (1) (b)]

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 ensuring that resident's SDM is notified within twelve hours of becoming aware of any alleged abuse of the resident, to be implemented voluntarily.

Issued on this 13th day of September, 2019

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

Original report signed by the inspector.