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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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 11, 2019	2019_704682_0008	028944-17	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 Niagara Long Term Care Residence
120 Wellington Street P.O. Box 985 NIAGARA-ON-THE-LAKE ON L0S 1J0

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

AILEEN GRABA (682)

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 18, 19, 20, 21, 25, 26, 27, 2019.

The following Critical Incident System inspection was conducted:
028944-17 related to prevention of abuse and neglect.

The following Complaint inspection (s) were conducted concurrently with this Critical Incident System inspection:
009155-18 related to prevention of abuse and neglect, personal support services
024211-18 related to nutrition and hydration, personal support services
032625-18 related to falls prevention, sufficient staffing
002015-19 related to sufficient staffing, personal support services

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Care (DOC); Assistant Director of Care (ADOC); Food Service Nutrition Manager (FSNM); dietary aid(s), registered staff; personal support workers (PSW); residents and families.

During the course of this inspection, the inspector(s) observed the provision of the care and reviewed clinical health records, investigation notes, daily assignment sheets, overtime logs, staffing schedules, meeting minutes, policy and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all residents were protected from abuse by anyone. O.Reg. 79/10, s. 2 (1) definition includes physical abuse as the use of physical force by a resident that causes physical injury to another resident.

A critical incident was submitted to the Director, related to resident to resident abuse. A clinical record review identified resident #001 had cognitive loss. The care plan identified resident #001 as having some responsive behaviours with strategies to minimize responsive behaviours. A clinical record review identified resident #002 had cognitive loss. The care plan identified resident #002 as having responsive behaviours with strategies to minimize responsive behaviours. Further review included a progress note which identified a physical altercation between resident #001 and resident #002. A progress note identified a subsequent altercation between resident #001 and resident #002. RN #102 had documented that resident #001 had caused an injury to resident #002. Resident #001 and resident #002 were separated. During an interview, the DOC confirmed that resident #001 and #002 had an incident on an identified date, but did not recall if any interventions were implemented to protect resident #002 from any further physical contact by resident #001. The home failed to protect resident #002 from physical abuse by anyone. [s. 19. (1)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, (b) strategies were developed and implemented to respond to these behaviours, where possible.

A critical incident was submitted to the Director, related to resident to resident abuse. A clinical record review identified resident #001 had cognitive loss.The care plan identified resident #001 had responsive behaviours with strategies to minimize the responsive behaviours. Further review included a progress note which identified a physical altercation between resident #001 and resident #002. A review of resident's #001 plan of care after the incident did not identify any additional strategies developed or implemented in relation to the incident that occurred. A progress note identified a subsequent altercation between resident #001 and resident #002. RN #102 documented in the progress notes that resident #001 caused an injury to resident #002. Resident #001 and resident #002 were separated. During an interview, RN #102 stated that both resident #001 and resident #002 have potential for responsive behaviours and altercations. During an interview, the Director of Care (DOC) did not recall whether strategies were developed and implemented in relation to the incident between resident #001 and resident #002. The home did not ensure strategies were developed and implemented to respond to resident's #001 behaviours in relation to the incident involving resident #002. 53. (4) (b)]

Issued on this 23rd day of April, 2019

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

Original report signed by the inspector.