Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 17, 2017	2016_357648_0011	032530-16	Resident Quality Inspection

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 Gibson Long Term Care Residence
1925 STEELES AVENUE EAST NORTH YORK ON M2H 2H3

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

JOVAIRIA AWAN (648), JANET GROUX (606)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 16, 17, 18, 21, 22, 23, 24, 25, and 28, 2016

The following complaint logs were inspected:
#01609-15 related to a critical incident system report alleging resident neglect;
002149-15 related to a complaint about staffing and lack of care residents;
004774-14 related to a complaint of injuries to a resident;
031817-15 related to a complaint of a resident being hit with a medication cart resulting in an injury;
007986-14 related to a complaint about housekeeping and missing dentures.

During the course of the inspection, the inspectors conducted observations of residents and home areas, medication administration , infection control prevention and practices, reviewed clinical health records, staffing schedules/assignments, minutes of Residents' Council and Family Council meetings, minutes of relevant committee meetings, and relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with the administrator, director of Care (DOC), assistant director of care (ADOC), environmental services manager (ESM), programs and support services lead, maintenance aide, registered practical nurses (RPN), registered nurses (RN), personal support workers (PSW), housekeeping staff, residents and substitute decision makers (SDM).

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **6 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	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with the Act.

The inspector observed, during the initial tour on November 16, 2016, at 0937 hours (hrs) on the first floor a Point of Care (POC) monitor with resident #009's personal health information visible to anyone walking by.

Interview with PSW #122 indicated he/she had forgotten to log off before leaving the area and confirmed the home's practice is to log off and close the screen before leaving and he/she stated this was not done. The PSW logged off from the POC after the inspector brought this to his/her attention.

Interview with the DOC stated it is the home's expectation for staff to sign off and lock the POC monitor before leaving the area.

2. The inspector observed along with PSW #123 and PSW #124, during the initial tour on

November 16, 2016, at 0948 hrs the POC screen located on the second floor with resident #010's personal health information displayed on the monitor visible for anyone walking by.

Interview with PSW #123 and #124 revealed PSW #122 was using the POC and had left the floor to go on his/her break and had forgotten to log off from the POC. He/she stated the home's practice was to log off and lock the POC monitor before leaving the area and stated this was not done.

The inspector observed PSW #124 log off and locked the POC monitor after the inspector had brought this to his/her attention.

Interview with the DOC stated the home's practice was to sign off and lock the screen before leaving the area. [s. 3. (1) 11. iv.]

2. The inspector observed, during the initial tour on November 16, 2016, at 0948 hrs the POC screen located on the second floor with resident #010's personal health information displayed on the monitor visible for anyone walking by.

Interview with PSW #123 and #124 revealed PSW #122 was using the POC screen and had left the floor for his/her break and had forgotten to log off from the POC. He/she stated the home's practice is to log off and lock the POC screen before leaving the area and confirmed this was not done. The inspector observed PSW #124 log off and locked the POC screen after the inspector brought this to his/her attention.

Interview with the DOC confirmed that the home's practice is to sign off and lock the screen before leaving the area.

Interview with the DOC confirmed that the home's practice is to sign off and lock the screen before
leaving the area. [s. 3. (1) 11. iv.]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

Review of a complaint an identified date forwarded to the Ministry of Health and Long Term Care (MOHLTC) reported concerns regarding resident#008's safety due to injuries the resident sustained which the home informed him/her were caused by a light bulb that had exploded in the spa/shower room while the resident was receiving care.

Review of the progress note entered by RN #120, on the identified date stated that he/she investigated after hearing a noise come from the shower room. The progress note stated that RN #120 observed PSWs #121 and #126 removing resident #008 from the spa/shower room. Inside of the shower room a lamp shade had into pieces. The note further stated that the resident had been in the process of being transferred from a Hoyer lift into a wheelchair.

Review of resident #008's progress notes indicated the resident sustained multiple superficial cuts on his/her skin.

Interview with resident #008 was not conducted as the resident is no longer in the home.

Interview with the SDM was not conducted as he/she requested not to be contacted.

Interview with PSW #121 was not conducted as the PSW was not available for an interview.

Interview with PSW #125 was not conducted as this PSW was not available for an interview.

Interview with RN # 120 indicated he/she was at the nursing station located close to the spa/room on the identified date, when he/she heard a very loud sound. The RN stated he/she quickly ran over to see what was going on and observed PSWs #121 and #125 coming out of the spa/shower room with resident #008. He/she stated PSW #121 and #125 told him/her the light bulb in the spa/shower room had exploded and injured the resident. RN #120 stated he/she went in the spa/shower room and stated when he/she

attempted to turn on the light switch, the light to the spa/shower room would not turn on. The RN revealed the spa/shower room was dark but he/she stated that he/she was still able to see that the glass cover that goes over the light bulb had "shattered" into a few pieces with some of the glass still intact and noted the light bulb had shattered too. RN #120 stated he/she ensured the light switch was in the "off" position and documented in the "Maintenance Log" book that the light bulb required to be replace.

Interview with the DOC revealed he/she was in the building on the identified date, and was notified by RN #120 that water had splashed from the shower onto the light fixture and stated, "quite a piece of glass fell from the light fixture". The DOC indicated he/she went to the unit and saw resident #008 had multiple scratches his/her skin and noted that the resident's had a bandage on it and indicated by the time he/she got up to the unit, he/she state there were no concerns. The DOC indicated RN #121 entered in the maintenance binder about the incident and stated it would have been followed up by maintenance the next morning.

Interview with the ESM stated his/her department were informed about a light bulb that required to be replaced on the unit the following day but were not aware that the light bulb had exploded and caused an injury to a resident. The ESM indicated if his/her department was informed of the incident as mentioned above, he/she would have followed up with an investigation to determine the cause and prevent another incident from happening again to ensure the home is safe for the residents. [s. 5.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

Review of a complaint dated on an identified date, forwarded to MOHLTC reported concerns regarding resident #008’s safety due to injuries the resident sustained which the home informed him/her were caused by a light bulb that had exploded in the spa/shower room while the resident was receiving care.

Review of the home's Wound Care Treatment policy #A LTC-CA-WQ-200-08-03 last revised on November 2015, indicated upon discovery of an alteration, staff will use the SKIN-Initial Skin and Wound in Point Click Care (PCC) to initiate a baseline assessment.

Review of resident #008's progress notes indicated he/she sustained multiple superficial cuts to the skin.

Further review of resident #008's PCC assessments did not indicate that an initial skin assessment was completed.

Interviews with RN #120 and #112 indicated it was the home's practice to complete an initial skin assessment for any skin impairment and confirmed that an initial skin assessment was not completed for resident #008.

Interview with the DOC confirmed the home’s expectation is for registered staff to complete an initial skin assessment for any resident with alteration in their skin integrity. [s. 8. (1) (a),s. 8. (1) (b)]

2. Review of complaint forwarded to the MOH on an identified date, reported resident #007 was hit by a medication administration cart which causing the resident to sustain a fracture to a specified area of the body.

Review of CIS report submitted on an identified date to the MOHLTC, reported resident #007 was hit by the side table of the medication cart as RPN #126 was pushing the medication cart to the nursing station. The resident lost his/her balance and fell to the floor. Further review indicated the resident verbalized pain to his/her. Resident #007 was

transferred to the hospital and was diagnosed with a fracture.

Review of the intake complaint indicated the SDM revealed the home had initially told him/her that resident #007 had just had a fall and did not inform him/her that the resident fell because he/she was hit by a medication cart. The SDM indicated the information provided to him/her changed and he/she was informed that the resident may have been “grazed/tapped by the medication cart. The SDM stated the home showed him/her a video of the incident and witnessed resident #007 being hit by the cart with such impact causing the resident to "actually fly to the other wall". He/she stated as soon as resident #007 fell to the floor, the video captured RPN #126 and an unidentified PSW immediately pick up resident #007 off the floor and walked him/her back to the room.

Review of the home's policy "Resident Fall", # LTC-CA-WQ-200-07-08, revised May 2016, directed staff to "record the incident clearly, concisely, and factually."

Review of resident #007's progress notes for the identified date, revealed documentation by RPN #126 stated the resident walked into a medication cart when he/she was moving the medication cart into the medication room and that the resident lost his/her balance and fell to the floor. Another entry by RPN #126 on the following day, indicated he/she was “dragging” the medication cart into the nursing station and as the medication cart was “rolling” into the nursing station, resident #007 “suddenly” started walked toward the medication and caused the medication cart to hit the resident.The progress notes indicated the RPN was not able to stop the medication cart from moving it and caused the resident to lose his/her balance and fall to the floor.

Interview with PSW #121 stated that he/she is on a leave of absence from the home and had other priorities at the time of the call and was unable to continue the interview.

Interview with RPN #126 was not conducted as contact number provided by the home was not in service. The inspector was informed at a later date RPN #126 was no longer in the country.

Interview with RN ##127 was conducted but he/she stated he/she does not recall much about the incident and was unable to answer the inspector's questions.

Interview with the DOC revealed he/she had viewed the incident on the home's video surveillance camera and indicated the home had questioned the accuracy of RPN #126 account of the incident. He/she stated that it was not until RPN #126 was shown the

video surveillance camera of the incident that he/she acknowledged had what actually happened. The DOC stated RPN #126 received a discipline for his/her actions. [s. 8. (1) (a),s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Record review of a CIS report submitted on an identified date reported an allegation of neglect of resident #027 by PSW #118. The CIS report submitted to the Director identified resident #027 had reported to RN #106 that he/she was not woken up for breakfast and had nothing to eat.

During the course of the inspection, record review of the home’s policy titled "Investigations" (policy number LTC-CA-WQ-100-05-01, last revised November 2014), identified steps and directions on how to conduct an investigation and document the findings related to the home. The policy outlined that a comprehensive investigation will be undertaken using the home's investigation form. The policy also required that a written report identifying the date of the investigation and pertinent information will be completed within 10 working days. The policy further indicated where an investigation involved submitting a critical incident report or other such report, regulatory body time frames for submission must be adhered to.

Interview with the homes DOC reported an investigation was conducted but the investigation form was not completed. The DOC was unable to demonstrate documentation for the investigation of the alleged neglect. [s. 20. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that, (d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks.

Review of a complaint made on an identified date forwarded to the MOHLTC reported concerns regarding resident #008's safety due to injuries the resident sustained which the home informed him/her were caused by a light bulb that had exploded in the spa/shower room while the resident was receiving care.

Review of a home's binder entitled, "Maintenance" indicated no procedures to ensure that plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks.

Review of the home's policy entitled, "Preventative Maintenance and Schedules/Calendar", #ALL-CA-ALL-505-02-03 revised January 2015, did not include a policy and procedure to ensure washroom fixtures and accessories are maintained and kept free from corrosion and cracks.

An interview with the Maintenance Aide and the ESM revealed the home completes audits regularly to ensure that washroom fixtures and accessories are maintained properly but were not able to demonstrate how and where the completed inspections for the washroom fixtures and accessories were, they stated all inspections completed by the home regarding maintenance services would have been located in this binder. [s. 90. (2) (d)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the report to the Director included the names of any staff members who were present at the incident.

Record review of a CIS report submitted on an identified, reported an allegation of neglect of resident #027 by PSW #118. The CIS report submitted to the Director identified resident #027 had reported to RN #106 that he/she was not woken up for breakfast and had nothing to eat. The CIS report noted a PSW was involved with the incident but did not identify the name of the alleged PSW.

Interview with the homes DOC confirmed he/she had identified the alleged PSW but had not included it in the report of the alleged incident to the Director. [s. 104. (1) 2.]

2. The licensee failed to ensure that a preliminary report is made to the Director within 10 days, followed by a final report within the time specified by the Director.

Record review of a CIS report submitted on an identified date reported an allegation of neglect of resident #027 by PSW #118. The CIS report submitted to the Director identified resident #027 had reported to registered nurse RN #106 that he/she was not

woken for breakfast and had nothing to eat. Review of the CIS did not identify an amendment. The CIS report noted a PSW was involved with the incident but did not identify the name of the alleged PSW.

Review of the LTCH.net CIS submission portal did not identify the CIS had been amended following the initial submission.

During the course of the inspection, record review of the home's policy titled "Investigations", policy number LTC-CA-WQ-100-05-01, last revised November 2014, identified steps and directions on how to conduct an investigation and document the findings related to the home. The policy further indicated where an investigation involved submitting a Critical Incident Report or other such report, regulatory body time frames for submission must be adhered to.

Interview with the homes DOC confirmed he/she had identified the alleged PSW but had not included it in the report of the alleged incident to the Director. The DOC confirmed an amended preliminary report was not submitted within 10 days to the Director with additional information related to the incident identifying the staff involved. [s. 104. (3)]

3. The licensee failed to ensure that a preliminary report is made to the Director within 10 days,followed b y a final report within the time specified by the Director.

Record review of a CIS report submitted on an identified date reported an allegation of neglect of resident #027 by PSW #118. The CIS report submitted to the Director identified resident #027 had reported to registered nurse RN #106 that he/she was not woken for breakfast and had nothing to eat. Review of the CIS did not identify an amendment. The CIS report noted a PSW was involved with the incident but did not identify the name of the alleged PSW.

Review of the LTCH.net CIS submission portal did not identify the CIS had been amended following the initial submission.

During the course of the inspection, record review of the home's policy titled "Investigations", policy number LTC-CA-WQ-100-05-01, last revised November 2014, identified steps and directions on how
to conduct an investigation and document the findings related to the home. The policy further indicated where an investigation involved submitting a Critical Incident Report or other such report, regulatory body time frames for submission must be adhered to.

Interview with the homes DOC confirmed he/she had identified the alleged PSW but had not included it in the report of the alleged incident to the Director. The DOC confirmed an amended preliminary report was not submitted within 10 days to the Director with additional information related to the incident identifying the staff involved. [s. 104. (3)]

Issued on this 21st day of February, 2017

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

Original report signed by the inspector.