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 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 sions de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 11, 2016	2016_291194_0014	003499-16	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

BALLYCLIFFE LODGE NURSING HOME
70 STATION STREET AJAX ON L1S 1R9

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

CHANTAL LAFRENIERE (194)

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): June 20, 21, 22, 24, 27, 28 and 29, 2016

Concurrently inspected Critical incident Log #009713-16, Log #016827-16, Log #019439-16 related to resident to alleged resident physical abuse, Log #004930-16 related to allegations of resident to resident sexual abuse and Log #010092-16 related to alleged staff to resident physical abuse.

During the course of the inspection, the inspector(s) spoke with Residents, Administrator, Director of Care (DOC), Corporate Nursing Consultant, Program Support Service Manager, BSO, MDS coordinator, Registered Nurse (RN), Registered Practical Nurse (RPN)and Personal support worker (PSW).
The inspector also observed staff providing resident care, reviewed of relevant policies, clinical health record of identified residents and investigations related to abuse incidents.

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)**
- **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	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. 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. Log #019349-16 related to resident #017 and #021

The licensee has failed to ensure 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.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

A Critical Incident Report (CIR) for allegation of resident to resident physical abuse was submitted to the Director on on an identified date for an incident that occurred the previous day.

The CIR indicates that two residents, #021 and #017 were involved. Resident #021 became upset and the altercation resulted in resident #021 sustaining an injury.

When interviewed the DOC indicated that the RN on duty at the time of the altercation was an agency staff, who did not immediately report to the Director. DOC completed the CIR the following day when the incident was reported. [s. 24. (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 by ensuring that agency staff immediately report any suspicions and information that it was based on to the Director related to 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 #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

The licensee has failed to ensure that steps taken were taken minimize the risk of altercations and potentially harmful interactions between resident #017 and resident #012 and co residents, by not identifying and implementing interventions.

Log #009713-16 involving resident #017 and #018.

Resident #017 has cognitive impairments and is independent with ambulation in the home.

A Critical incident report(CIR) was submitted for allegation of resident to resident physical abuse. An un-witnessed altercation between resident #017 and #018 occurred resulting in injury to resident #018.

Log #016827-16 involving resident #017 and #021.

A CIR was submitted for allegation of resident to resident physical abuse. An altercation between resident #017 and resident #021 occurred, resulting in injury to resident #021.

All staff interviewed, RPN #104 (BSO), RPN #105, #106, #110, RN #100, PSW #108 and DOC indicated that the intervention for resident #017 was to separate and redirect the resident back to bedroom when aggression was noted. Staff interviewed identified triggers for resident #017 such as dislike for opposite sex, resident #020, co-residents displaying affections towards one another, loud and busy areas such as unit lounge and dining room. All staff interviewed indicated that at times resident #017 can exhibit behaviours without any predictability.

The plan of care for resident #017 does not identify that the responsive behaviour can be unpredictable at times, or identify a dislike for opposite sex, loud/busy areas, display of affections towards others or co- resident #020 as being triggers for resident # 017's verbal and physical aggression.

Review of the clinical health record for resident #017 for the period of 5 months was completed and identified 36 incidents of verbal aggression towards co-residents and 12 incidents of physical aggression towards co-residents.

Resident #017 had been seen by outside resources but there were no recommendations or notes provided to the home following the visits. Two medication changes were made for resident #017 over a four month period.

Review of the clinical health record and interview with staff did not provide evidence that steps had been taken to minimize the risk of altercations between resident #017 and co residents at the home. Interventions have not been identified or implemented related to numerous incidents of verbal and physical altercations between resident #017 and co residents in the home.

Log #016827-16, 04930-16 and Log #019439-16 related to responsive behaviour, sexual and physical abuse involving resident #012.

Log #01687-16 related to resident #012 and #013

Resident #012 was recently relocated in the home for exit seeking behaviours. MDS assessment indicated an increase in aggression over a three month period for resident #012 and the resident's cognition levels remained unchanged.

A Critical incident report indicated an altercation between resident #013 and #012, resulting in an injury to resident #013.

Log #04930-16 related to resident #012 and #013.

A CIR indicated resident #012 entered resident #013's room and made a sexually inappropriate comment.

During an interview with inspector #194 resident #012 had difficulty carrying on a conversation, was unable to understand the intent of the questions and unable to focus on the topic being discussed. Resident # 012 had no recall of the incidents identified when asked by the inspector.

All staff interviewed, RPN #109, 105, 104(BSO), PSW #118, RN #100, #101 and DOC described resident #012's responsive behaviours as exit seeking, wandering in/out of rooms, verbal and physical aggression towards staff. The inspector was informed that at times the behaviours can be unpredictable and escalate quickly. Triggers identified by staff interviewed were, the location of previous home, being given direction by multiple people, being told "no" and pain.

Review of the clinical health record for resident #012 for the period of four months was completed and identified 19 incidents of wandering during the evening and nights shifts.

Altercations between resident #012 and resident #013 were noted in the progress notes over a four month period. The one CIR for altercation was submitted, the remainder of the altercations were wandering into the co-resident's room.

The plan of care for resident #012 indicated the responsive behaviours as; wandering without purpose, being resistive to care, exit seeking, verbally and physically aggressive towards staff and co residents and sexually inappropriate towards staff. The plan of care does not identify interventions for the wandering behaviour that is occurring in the evening and night shifts. The plan of care does not identify interventions for sexually inappropriate behaviour toward co-residents.

The plans of care for resident #017 and #012 did not identify and implement interventions to minimize the risk of altercation between co residents as identified by staff interviewed and documentation in the clinical health records. [s. 54. (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 by ensuring that steps are taken to minimize the risk of altercations and potentially harmful interactions between resident #017, #012 and co-residents by identifying and implementing interventions, to be implemented voluntarily.

Issued on this 11th day of August, 2016

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

Original report signed by the inspector.