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

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 # / No de registre	Type of Inspection / Genre d'inspection
Aug 29, 2017	2017_594624_0016	000996-17, 003513-17, 003690-17, 003829-17, 005537-17, 011266-17, 018916-17	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 Ballycliffe Long Term Care Residence
70 STATION STREET AJAX ON L1S 1R9

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

BAIYE OROCK (624)

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): August 9, 10, 11, 14, 15, 16, 17, 21, 22, and 24, 2017

The following logs were inspected concurrently:
Logs #000996-17 and #003829-17 - Related to falls management,
Logs #003690-17 and #003513-17 - Related to an allegation of resident to resident abuse,
Logs #005537-17, #018916-17, and #011266-17 - Related to allegations of staff to resident abuse/neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Corporate Nursing Consultant, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents, and family members.

Several observations were made of resident to resident interactions in the home, residents' rooms, as well as staff to resident interactions during the provision of care. A review was also completed of the resident's health records, the Licensee's internal investigations and relevant policies and procedures related to falls management, zero tolerance of resident abuse, and the management of responsive behaviors.

The following Inspection Protocols were used during this inspection:
Falls Prevention
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. 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 ensure that care set out in the written plan of care was provided

to resident #004 as specified in the plan related to a specified intervention for falls prevention.

Related to log #003829-17,

On a specified date, a Critical Incident Report was submitted to the Director related to resident #004 who had fallen, sustained an injury and was sent to hospital with a resulting change in condition. Resident #004 is currently assessed as being at high risk of falling.

According to the resident’s current written plan of care, staff are to ensure that a specified intervention to prevent falls was in use when the resident was in bed.” On two separate occasions on a specified date, the resident was observed by Inspector #624 to be sleeeping in bed with the specified intervention not in use. PSW #115 and PSW #114, who were respectively near the resident's room at both time of the observations, indicated to Inspector #624 that resident #004 is at high risk of falling and that the said intervention had to be in use when the resident was in bed. On each occasion, the PSWs proceeded to apply the intervention onto the resident.

In an interview with the Administrator on a specified date, the Administrator indicated that the Licensee’s expectation is that care should be provided to residents as specified in the plan and in this case where the intervention was not in use while the resident was in bed, staff were not providing care as specified in the plan. [s. 6. (7)]

2. The licensee failed to ensure that care set out in the written plan of care was provided to resident #003 as specified in the plan related to reapproaching.

Related to log #018916-17,

A Critical Incident Report (CIR) was submitted to the Director on a specified date and time. According to the submitted CIR, on a specified date, the Substitute Decision Maker (SDM) of resident #003 had complained to RN #110 that at a specified time when the SDM came to visit resident #003, a set of interventions in the resident's care plan that were supposed to have been provided to the resident, had not been provided.

A review of the current plan of care for resident #003 indicated that the resident had all the said interventions listed to be provided over a specified period. The same plan of care also indicated that resident #003 will refuse interventions but that when refusal of

interventions occurred, staff are to reapproach after 10 minutes to attempt the interventions again.

In an interview conducted on a specified date with RN #110 regarding the complaint, she indicated that on the date the complaint was made, he/she had been called to resident #003’s room as the resident’s SDM wanted to talk to him/her. The RN stated that when he/she arrived, he/she saw the SDM assisting the resident with some of the interventions that should have been provided to the resident by the time he/she arrived at the resident's room. The SDM wanted to know why the set of interventions listed in the resident's care plan had not been provided to resident #003 as specified in the plan.

PSW #112, primary care giver for resident #003, who had worked the day shift on the day of the incident was interviewed on a specified date relating to the incident and the PSW indicated that he/she had transported the resident back to the resident's room after lunch, attempted to provide the set of interventions but that the resident had refused. The PSW indicated that he/she had reported the refusal to the Day Charge Nurse, RN #113 but did not reapproach the resident again before leaving at the end of her shift, approximately one hour after the initial refusal of care by resident #003. PSW #111, primary care giver for resident #003, who worked the evening shift right after PSW#112 was interveiwed as well about the incident and PSW #111 indicated that after starting his/her shift, he/she was busy with other residents and before getting to resident #003, the resident’s SDM had already assisted the resident and complained to RN #110.

A review of resident #003’s hallway surveillance video on the day of the incident indicated that PSW #112 transported resident #003 back to the resident's room after lunch, stayed in the resident's room for about five minutes, left the floor about 20 minutes later after assisting another resident and was not observed to return again to the floor on that day. The reviewed video further indicated that for about one hour after PSW #112 initially exited resident #003's room, no staff member was seen to enter resident #003's room.

A review of resident #003’s progress notes revealed that RN #113 had documented resident had refused care during the day shift, on the day of the incident. The progress notes reviewed for the evening shift did not indicate any documentation of care refusal or attempts at providing care to the resident. In an interview with the evening Charge Nurse, RN #110, he/she indicated that no PSW staff member reported any attempts at providing care to the resident or if the resident refused care between the beginning of his/her shift and before receiving the complaint from the resident's SDM, a period spanning two hours

after PSW #112 was done her day shift.

In an interview with the Administrator on a specified date and time, the Administrator indicated that the expectation in the home is that staff are to provide care to residents as specified in the resident's plan of care. Regarding resident #003, the Administrator indicated that between the initial attempt at care provision by PSW #112 and when the SDM complained, resident #003 was not reproached.

The Licensee failed to provide care to resident #003 as specified in the resident's written plan of care, by not reapproaching the resident when the resident initially refused care. [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 by putting in place a process and that the process is being monitored, to ensure that care set out in the plan of care is provided as specified in the plan for resident #004 related to a specified intervention and for resident #003 related to reapproaching when incidents of care refusal occur, 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 has failed to comply with its Policy "Abuse Allegations and Follow-Up", policy no: LTC-CA-WQ-100-05-02"

According to the Long-Term Care Homes Act, 2007, section 20. (1), 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.

The Licensee's policy "Abuse Allegations and Follow-Up", policy no: LTC-CA-WQ-100-05 -02, dated July 2010 and lastly reviewed on July 2016, states:
"Abuse reporting is immediate and mandatory. All employees are required to, as a matter of Chartwell's internal reporting structure to ensure safety for all, report immediately to their respective supervisor/person in charge of the building when:
-An abuse is witnessed and/or
-An abuse is suspected and/or
-At any time information or knowledge of an allegation of an abuse is received or learned from any person"

Related to log #005537-17,

According to a Critical Incident Report (CIR) submitted to the Director on a specified date, a Student PSW #107 while completing a placement in the home witnessed an alleged verbal and physical abuse of resident #002 by PSW #108 that occured on another specified date. This allegation was not reported to neither the Registered Practical Nurse (RPN), Registered Nurse (RN), nor the Director of Care (DOC) until two days later when a hand written note was received by the DOC. Student PSW #107 has since completed the training and no longer works for the home while PSW #108 has not been back to work since the date of the incident with both staff not available for interview.

On a specified date during separate interviews completed by Inspector #624 with PSW #102, PSW #103, and Charge Nurse RPN #104, all staff members indicated that the expectation in the home is that any allegation of witnessed or suspected abuse of a resident by anyone has to be reported immediately to one's immediate supervisor.

In an interview on a specified date with the Administrator and the Corporate Nursing Consultant, both indicated that the Licensee's expectation is that any alleged abuse must be reported immediately to the immediate supervisor but that staff are aware they can equally call the Director directly. In the same interview, the Administrator indicated that Student PSW #107, just as any other staff of the home, had completed training on the Licensee's abuse policy and should have reported the allegation immediately to the RPN, RN or DOC on the date when the incident occurred. [s. 20. (1)]

2. Related to log #003690-16,

Another Critical Incident Report (CIR) was submitted to the Director on a different specified date. According to the submitted CIR, on the specified date in question, a Recreation Aide had reported to RPN #119 that the Recreation Aide had witnessed resident #007 attempt to inappropriately touch resident #006. This allegation was not reported to the Charge Nurse by RPN#119. The incident was discovered the following day and reported to the Director.

In an interview with RPN #119 on a specified date, the RPN indicated that the Licensee`s expectation is that anyone who witnesses, suspects or knows of abuse or an allegation of abuse, that person has to report immediately to their immediate supervisor. RPN #119 indicated that he/she had been busy with the medication pass when the Recreation Aide reported the incident to him/her and he/she in turn forgot to inform the Charge Nurse (an RN) who was his/her immediate Supervisor at the time of the incident. In an earlier interview on a specified date completed at different times by Inspector #624 with PSW #102, PSW #103, and Charge Nurse RPN #104, all staff members indicated that the expectation in the home is that any allegation of witnessed or suspected abuse of a resident by anyone has to be reported immediately to one’s immediate supervisor.

In an interview on a specified date with the Administrator and the Corporate Nursing Consultant (covering the DOC position), both indicated that the Licensee’s expectation is that any alleged abuse must be reported immediately to the immediate supervisor but that staff are aware they can equally call the Director directly. [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 by putting in place a process and that the process is being monitored, to ensure that the licensee complies with its Policy “Abuse Allegations and Follow-Up”, policy no: LTC-CA-WQ-100-05-02," specifically related to staff immediately reporting alleged or witnessed incidents of abused to their immediate supervisor, to be implemented voluntarily.

Issued on this 30th day of August, 2017

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

Original report signed by the inspector.