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 soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 30, 2018	2018_603194_0002	000990-18	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 Ballycliffe Long Term Care Residence
70 STATION STREET AJAX ON L1S 1R9

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

CHANTAL LAFRENIERE (194), BAIYE OROCK (624), SARAH GILLIS (623)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 15, 16, 17, 18, 19, 22, 23, 24, & 25, 2018

Inspections completed Log #013481-17 Follow up inspection related to Compliance Order s. 62 related to Licensee co-operating with the Family Council, Log #021372-17 related to allegations of staff to resident neglect, Log #023776-17 related to unexpected death, Log #029224-17 related to fall, Log #001541-18, #001264-18 related to personal care concerns

During the course of the inspection, the inspector(s) spoke with residents, Families, Administrator, Director of Care (DOC), Physician, Social Worker (SW), Environmental Service Manager (ESM), Programs and Support Service Manager (PSSM), Nutrition Manager, Housekeeping staff, Registered Nurses (RN), Registered Practical Nurses (RPN) and Personal Support Worker (PSW)

Inspectors completed a tour of the building, observed staff to resident provision of care, Infection Control, Medication Administration, Skin and Wound and Housekeeping processes. Reviewed clinical health records of identified residents, Resident Council Minutes, Family council Survey and relevant policies.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 62.	CO #001	2017_603194_0018	194

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The Licensee failed to ensure that the written plan of care for resident #015 set out clear directions to staff and others who provide direct care to the resident.

Related to log # 001541-18

During interview with inspector #624 the SDM for resident #015 indicated that a private companion whom had been hired to work with the resident, reported that on an identified date that, no PSW staff member came into the resident's room to provide care to the resident.

The resident's current written plan of care indicated that "Staff provide comfort care, mouth care, turning/repositioning and give medication as per MD order for discomfort."

The written plan of care did not contain any specific definition of the roles and responsibilities for the private companion.

In an interview the resident's SDM indicated that a meeting was conducted with the Director of Care (DOC) in which the SDM had informed the DOC that the private staff was hired for companionship only. Separate interviews were completed on an identified date with PSWs #119, #120, and #121, who had worked the identified shift. PSW #119, and #120 did not remember working with resident #015 on the said day, while PSW #121 indicated having been in the resident's room, observed the resident who was fine at the time and told the private companion that staff would be returning later. A review of the resident's electronic medication administration record (eMAR) on the identified date indicated that registered staff where in the resident's room five separate time during the identified time, to provide different interventions for resident #015.

PSW #119, #120, #121 and #123 where asked separately about the licensee's expectation on providing care to residents who have a private companion. PSW #123 and #120 indicated that the PSWs employed in the home are to provide care to residents irrespective of whether or not they have a private companion. PSW #121 indicated that the private companion, as they are constantly with the resident are expected to inform the home's PSW about the residents needs. PSW #119 indicated that the provision of care, would depend on what the family had stated the private companion was supposed to do for the resident.

In an interview the Director of Care (DOC) indicated that there was no clear direction to the PSW staff in the home related to the roles and responsibilities of private companion involving resident #015. [s. 6. (1) (c)]

2. The Licensee failed to ensure that the substitute decision maker (SDM) of resident #026 was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Related to log #001264-18

During an interview with inspector #624 the SDM indicated that resident #026 was administered a medication without the SDM's consent.

A review of the physician's order for resident #026 indicated that on an identified date the resident was ordered a new medication. Review of the residents electronic medication

administration records (eMAR) for the identified period indicated that the new medication was signed as administered to the resident on three consecutive days. A review of the residents health records did not provide evidence that the resident's SDM was notified of the new medication.

Separate interviews with DOC, RPN #109 and RPN #122, who had processed resident #026's order for the new medication were completed . RPN #109 and #122 indicated that the licensee's expectation whenever a new medication is ordered, would be that the resident's SDM is to be notified before the medication is administered to the resident. RPN #122 indicated that the resident #026 's SDM had not been notified of the new medication.

The licensee failed to give the SDM of resident #026 the opportunity to fully participate in the development and implementation of the resident's plan of care by not notifying the SDM of a new medication. [s. 6. (5)]

3. The licensee has failed to ensure that the care set out in the plan of care for resident #022 related to continence care was provided as specified in the plan.

Related to Log #023776-17

The plan of care for resident #022 indicated that extensive assistance was required for all ADLs and mobility. Resident #022 was incontinent of both bowel and bladder.

Review of resident #022's continence protocol which was part of the resident's plan of care indicated, specific treatments for management of the residents continence.

Review of the clinical health record for resident #022 was completed and identified a period of ten days where the resident was administered medication on two separate dates for continence management, which were not specific to the continence protocol for the resident.

On an identified date, resident #022 was provided a continence assessment and was noted to be in distress. The resident #022 was transferred to hospital for further assessment and treatment.

A Critical incident submitted to the Director, indicated that
-resident #022 was transferred to hospital related to continence distress, where further

assessment and treatments were provided.

The plan of care for resident #022 was not provided as specified related to the continence protocol resulting in a transfer to hospital for further assessment. [s. 6. (7)]

4. The licensee failed to ensure that when resident #026's care needs changed, the resident was reassessed and the plan of care was reviewed and revised.

Related to Log #001264-18

During an interview with inspector #624 the resident's SDM indicated that, resident #026 had a medical condition which was not treated for a number of days.

A review of the admission progress note indicated that during the resident's admission, the resident's SDM informed the home of the resident's tendency to have an identified medical condition repeatedly.

A review of the resident #026's progress notes was completed and indicated that on an identified date, a specific test was conducted. The test results would have been available electronically for the registered staff at the home three days later. The progress notes as well as the physician's orders indicated that treatment for resident #026 was not started until eight days later.

In an interview, RPN#122 indicated all Registered staff in the home have access to the on line reporting system where the resident's results can be reviewed.

In a further interview with the Director of Care (DOC) , it was indicated that the licensee expectation is that Registered staff would access the on line reporting system to obtain results and act on them accordingly.

On an identified date a specific test for resident #015 was conducted, identifying a change in the resident's condition three days later. The plan of care for resident #015 was not reviewed or revised related to the assessment for another eight days. [s. 6. (10) (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:
-Clear directions are provided in the plan of care related to expectations of PSW's when a private companion is involved,
-POA of resident #026 is given the opportunity to participate fully in the development and implementation of the resident's plan of care,
-the care set out in the plan of care is provided to residents as specified in the plan related to continence,
-when residents are reassessed, including specific treatments, that the plan of care is revised accordingly, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done with in accordance with this Act and regulations is complied with.

The licensee's Policy #LTC-CA-WQ-200-07-19 – Physical Restraint (revised December 2017) indicated the following:
Procedures:

2.B. Consent
ii. Once the Resident SDM/POA questions and concerns are addressed the resident or

SDM/POA will sign wither the Consent for Physical Restraint or the Waiver Not to Use Physical Restraint.

iii. Annually the Consent for Physical Restraint Form is to be reviewed with the resident, family and or POA as part of the annual care conference and resigned.

Resident #008 was admitted to the home with diagnosis that included Alzheimer's disease.

Resident #008 was observed on an identified date to be sitting in a wheel chair in the tilted position with a seat belt fastened in place. The resident was unable to undo the seat belt when asked to do so by Inspector #623.

Review of the clinical records for resident #008 identified in the written plan of care that a seat belt restraint was to be used in the wheel chair for safety. A current physicians order for the use of the seat belt as a restraint was available in the residents chart. After reviewing the clinical records for resident #008, the Inspector was unable to verify that a current consent for the use of the seat belt restraint had been completed by the licensee.

During an interview with Inspector #623, RN #102 indicated that resident #008 had a seat belt in a tilted wheel chair and the seat belt was considered a restraint. RN indicated that the licensee's expectation is that the use of the restraint is to be evaluated quarterly and the consent is to be signed as completed initially by the SDM and signed as reviewed at the annual care conference for consent to continue the use of the identified restraint. RN #102 indicated being the lead for the annual care conference for resident #008 on an identified date and at that time the consent was not reviewed and signed by the SDM. The RN indicated there is no current consent on record, signed by the SDM for the use of the seat belt restraint for resident #008.

During an interview with Inspector #623, the Director of Care (DOC) #101 indicated that it is the expectation of the licensee that the use of a restraint is reviewed at the annual care conference with the resident or the resident's SDM and that the consent will be resigned annually. The DOC indicated that after reviewing the clinical records for resident #008, the annual consent for the use of restraint was not completed at the care conference as indicated in the policy #LTC-CA-WQ-200-07-19 – Physical Restraint (revised December 2017)

The licensee's policy #LTC-CA-WQ-200-07-19 – Physical Restraint was not complied with. [s. 29. (1) (b)]

Issued on this 6th day of February, 2018

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

Original report signed by the inspector.