Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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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
Aug 15, 2019	2019_674610_0025	011153-19, 011888-19	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 London Long Term Care Residence
2000 Blackwater Road LONDON ON N5X 4K6

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

NATALIE MORONEY (610)

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): July 25, 29, 2019

The following Critical Incidents (CI)'s were completed concurrently during this inspection:
Critical Incident (CI) #2919-000009-19, Log #011888-19 was completed related to prevention of abuse and neglect and responsive behaviours.
Critical Incident (CI) #2919-000007-19, Log #011153-19 was completed related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Personal Support Workers, Resident Assessment Instrument and Behavioural Support Nurse, Registered Nurses, and Registered Practical Nurses, and resident's.

The inspector also reviewed relevant documentation, policies, conducted interviews and observed resident care areas.

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	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 :

The licensee has failed to ensure that residents were protected from abuse by anyone

and free from neglect by the licensee or staff in the home.

This inspection was completed related to Critical Incident report (CI) submitted by the home and received by the Ministry of Health and Long-Term Care. Review of the CIS report showed that an identified resident physically struck another resident that resulted in an injury to the victim.

The Ontario Regulation 79/10 defined "physical abuse" means c) the use of physical force by a resident that causes physical injury to another resident;

The Ontario Regulation 79/10 stated that every licensee of a long-term care home shall ensure that, (a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed because of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents;

Documented evidence showed that the identified resident had a history in the home of physical and verbal aggression with fellow residents and staff at the home.

The license policy Resident Safety and Risk Management; Responsive Behaviours Aggressive or Violent Episodes stated in part; In situations where the aggressive or violent behavior poses a risk to other in the home, the home will provide one to one staffing until the situation was diffused and the risk is minimized. "Where applicable the home will contact the regulatory body for payment of the 1:1 time through the provincial government". If the resident cannot be safely managed at the home and there was a physician; staff should proceed with a transfer of the resident to the hospital for a psychiatric assessment.

Documented evidence showed that for a specific period the identified resident had been verbally abusive toward other residents in the home and physically aggressive toward other residents in the home.

Review of record documentation showed staff had been completing care at the beginning of their shift and did not reflect the care related to the identified behaviors that had been occurring.

Documented evidence by the physician suggested the home provide one on one supervision to ensure other resident safety in the home.

The Inspector completed observation and had observed the identified resident acting inappropriately toward other residents in the home the identified resident was also shouting. During the observation there was no staff present providing monitoring.

An assessment had been completed related to the identified resident behaviours however those recommendations had not been implemented.

The Director of care (DOC) acknowledge that they had not revised and updated the plan of care for the identified resident.

The Administrator acknowledge that staff had been documenting care at the beginning of their shift on days and were not capturing the identified residents behaviours and that the expectation was that staff would not complete this documentation till the end of their shift.

Both the Administrator and the DOC stated that the identified residents behaviours had been escalating.

The home has failed to ensure that the identified resident was protected from abuse by anyone.

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 to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

The licensee has failed to ensure that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences.

This inspection was completed related to a Critical Incident report submitted by the home and received by the Ministry of Health and Long-Term Care. Review of the CIS report showed that an identified resident had physically struck another resident that resulted into in an injury to another resident.

The Inspector had requested the annual evaluation from the DOC for the homes policy to promote zero tolerance of abuse and neglect of residents and the improvement that were required to prevent further occurrences.

The home was not able to produce documented evidence that the annual review had been completed.

The Administrator acknowledge that the home had failed to complete an evaluation regarding the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences.

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 to ensure that that at least once in every calendar year, an evaluation was made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences, to be implemented voluntarily.

Issued on this 15th day of August, 2019

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

Original report signed by the inspector.