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 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
Jan 3, 2019	2018_530726_0011	027458-17, 001683-18, 009422-18, 031863-18	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 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

REBECCA LEUNG (726), SUSAN SQUIRES (109)

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): December 20, 21 and 27, 2018

The following intakes were inspected during this inspection:
CIS intake logs #001683-18, 009422-18, 031863-18, 027458-17 related to falls prevention

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, Family Services Manager, Occupational Therapist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents, family member and substitute decision-maker (SDM).

The inspectors conducted observations of residents and reviewed clinical health records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
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. 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:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right not to be neglected by the licensee or staff was fully respected and promoted.

Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date related to an unwitnessed fall incident involving resident #001. The CIS report indicated that resident #001 has had multiple falls prior to the critical fall incident that occurred on an identified date. Review of post fall incident report for an identified date indicated that resident #001 was found on the floor in another resident's room. Post-fall assessment was completed by the registered staff. On-call physician and the family were notified. Resident #001 was transferred to the emergency department for assessment when they complained of pain in a specific body part later after the fall incident. Review of progress notes indicated that resident #001 was admitted to the hospital after being diagnosed with a specific injury. Review of hospital discharge notes and progress notes indicated that resident #001 received a specific treatment on an identified date and was transferred back to the home on an identified date.

Review of physiotherapist's (PT) assessment and plan for an identified date indicated that resident #001 received specific physiotherapy treatment and could stay in their mobility device as per their tolerance, and resident #001 was required to be monitored as they were not following direction, and they were not cooperative.

Review of resident #001's Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment completed on an identified date indicated specific functional issues and observations of responsive behaviours. Review of the plan of care indicated the team had not developed specific strategies to manage the responsive behaviours presented by resident #001 since admission.

Review of progress notes indicated that resident #001 had another unwitnessed fall incident on an identified date after they returned from the hospital. Review of fall history indicated that resident #001 has had multiple falls since admission. The fall incident report for the identified date indicated resident #001 was taken from the nursing station back to their bed to be changed. PSW #110 left resident #001 alone in their room to get help from their partner for transferring resident #001 back to mobility device before lunch. When PSW #101 got back to the room, they found resident #001 on the floor. PSW #110 then called RN #101, who went in and found resident #001 on the floor, bearing weight on their hands. The post-fall assessment indicated that resident #001 did not sustain any injury.

In an interview, PSW #110 clarified the fall incident occurred to resident #001 on the identified date. PSW #101 stated that they took resident #001 in the mobility device from the nursing station to resident #001's room. PSW #110 then left resident #001 sitting in the mobility device alone in their room unattended and went out to find their partner to help transfer resident #001 to bed. PSW #110 walked down to the dining room and asked their PSW partner for help. Their PSW partner was busy at that time, but they agreed to come help PSW #110 later. PSW #110 then went back to resident #001's room and saw resident #001 sitting on the floor. PSW #110 then went to call RN #101 to check resident #001. PSW #110 confirmed they were aware that resident #001 had history of multiple falls and remained at high risk for falls after the specific surgery. PSW #110 stated they could have taken resident #001 with them when they went to find their partner for help, or stayed with resident #001 in the room and used the call bell to request help from their partner.

In two separate interviews, when inspector reviewed the fall incident which occurred to resident #001 on the identified date with RN #101 and RN #104, they both stated PSW #110 could have stayed with the resident #001 in the room and used the call bell to ask for help from their partner. RN #104 indicated that the intervention for reminding the staff not to leave resident #001 unattended should have been added to their care plan.

Review of resident #001's current care plan indicated that the interventions for fall prevention were not reviewed and updated on or after the last fall incident occurred on the identified date until the day when the inspector entered the home to initiate the CIS inspection.

In summary, PSW #101 left resident #001 under vulnerable conditions unattended in their room to get help from their partner resulting in another fall incident on the identified date. In addition, the staff neglected to review and revise resident #001's plan of care after the fall incident in a timely manner to ensure close monitoring was initiated for resident #001 to prevent the recurrence of similar fall incident in the future. The licensee has failed to ensure that the resident #001's right not to be neglected by the staff was fully respected and promoted. [s. 3. (1) 3.]

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 the residents' right not to be neglected by the licensee or staff is fully respected and promoted, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies were developed and implemented to respond to the resident demonstrating responsive behaviours.

The Ministry of Health and Long-term Care received a critical incident report (CIR) related to a fall which occurred on an identified date. According to the CIR, the resident had multiple prior falls. On the date of fall, the resident was found sitting on the floor in another resident's bedroom. The CIR further stated that the resident had responsive behaviours.

Review of the progress notes for a specified date range identified multiple entries indicating that the resident exhibited responsive behaviours. There were no interventions identified to manage these behaviours other than redirection by staff.

Review of a document entitled "My Story" is on the health record for resident #001. Within this document the resident is asked some questions about themselves including what upsets them and how will the home know when the resident is upset. Resident #001 and their SDM provided responses to the questions. There is no indication that this information was used to develop a plan of care. During an interview staff member #107 told the inspector that they had completed the document entitled "My Story" for resident #001. Staff #107 stated that the resident's statements are considered triggers for responsive behaviours.

Review of the plan of care of a specified date indicated that there was no plan of care in place for resident behaviours. There was no plan in place for the triggers that were identified in the "My Story" document. A plan of care was not put into place until after inspectors were asking for the plan.

During an interview PSW #100 told the inspectors that they did not know what else to do with resident #001 because the resident is very difficult to manage. They try to keep resident on a routine but cannot watch them constantly because they are tending to other residents.

During an interview, RN #101 told the inspector that she was unaware of what resident #001's behaviour triggers were and did not believe that the resident had behaviours. When asked if a referral had been made to the behavioral support persons, RN #101 told the inspector that none had been made.

Several observations of the resident made on identified dates found the resident to be exhibiting responsive behaviours.

This finding is based on the interviews, observations and record reviews which indicated that the resident had responsive behaviours prior to the incident. There were no interventions identified. Resident #001 continued to have responsive behaviours after returning from hospital and during the inspection. Staff were unaware of what interventions to apply and were unaware of whether or not the resident even had responsive behaviours and there was no involvement with the behavioural support staff member until after inspectors' findings. Results of inspection were communicated to staff member #103. [s. 53. (4) (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 to ensure strategies are developed and implemented to respond to the residents demonstrating responsive behaviours, where possible, to be implemented voluntarily.

Issued on this 3rd day of January, 2019

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

Original report signed by the inspector.