Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: March 8, 2023

Inspection Number: 2023-1383-0002

Inspection Type:
Complaint
Critical Incident System

Licensee: Trilogy LTC Inc.

Long Term Care Home and City: Chartwell Trilogy Long Term Care Residence, Scarborough

Lead Inspector	**Inspector Digital Signature**
Ana Best (741722)	Ana G. Best Digitally signed by Ana G. Best Date: 2023.03.29 14:50:48 -04'00'

Additional Inspector(s)
Amandeep Bhela (746)

INSPECTION SUMMARY

The inspection occurred on the following date(s):
January 30, 31, 2023, February 2, 3, 7-9, 13-17, 21, 2023. February 6, 2023, as on off-site inspection.

The following intake(s) were inspected:

- Five intakes related to falls prevention and management program.
- Five intakes related to alleged staff to resident abuse.
- One intake related to responsive behaviours management.
- One intake related to alleged resident to resident abuse.
- One intake related to a complaint of neglect, plan of care.
- One intake related to a complaint of responsive behaviours.
- One intake related to a complaint of unknown cause of injury.
- One intake related to unknown cause of injury.
- One intake related to alleged staff to resident neglect.
- One intake related to staff to resident emotional abuse.
- One intake related failure breakdown of staff communication response system.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non- compliance with O. Reg. 246/22 s. 102 (2) (b). Infection Prevention and Control (IPAC) Standard section 9.1 (f)

1) The licensee has failed to ensure that Additional Precautions were followed in the IPAC program in accordance with the Standard for Long-Term Care Homes issued by the Director, dated April 2022.

Rationale and summary

Specifically, the licensee did not ensure that the process for application and removal of personal protected equipment was followed as required by Additional Requirement under the IPAC standard. The IPAC Standard for Long-Term Care Homes, section 9.1 states the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At a minimum, Additional Precautions shall include additional PPE requirements including appropriate selection, application, removal, and disposal.

During this inspection, the home was in a respiratory outbreak on different units. The IPAC lead indicated PPE required on outbreak units were surgical mask and face shield. This requirement applied to everyone in hallways and rooms that were not part of isolation.

During initial IPAC tour, a visitor was observed to not wear the appropriate PPE after exiting a resident's room.

On two separate occasions, two PSWs working on an outbreak unit, were observed not wearing the appropriate PPE with others present in the surrounding. Both PSWs confirmed they were not wearing the specific PPE during their shift, as per home's process during outbreak.

Failure to ensure that staff and visitors participated in the implementation of the IPAC program related to proper use of PPE may have led to further transmission of infectious agents during respiratory outbreak.

Sources: Observations, interviews with IPAC lead, visitor, and PSWs.

[741722]

Non- compliance with O. Reg. 246/22 s. 102 (2) (b). Infection Prevention and Control (IPAC) Standard section 9.1 (d)

2) The licensee has failed to ensure that Routine Precautions were followed in the IPAC program in accordance with the Standard for Long-Term Care Homes issued by the Director, dated April 2022.

Rationale and summary

In accordance with the IPAC Standard for Long Term Care Homes, April 2022, section 9.1 (d) directs the licensee to ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At a minimum, Routine Practices shall include proper use of PPE, including appropriate selection, application, removal, and disposal.

On an identified date, a student was observed with their surgical mask below their chin, with others were present in the surrounding. Once approached by Inspector #741722, the student acknowledged not wearing the mask appropriately while walking down the hallway.

Failure to ensure staff wore their face mask appropriately, increased the risk for residents and staff of transmission of infectious agents.

Sources: Observations, interviews with IPAC Lead, and student.

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WRITTEN NOTIFICATION: COMMUNICATION AND RESPONSE SYSTEM

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 20 (g)

The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that uses sound which is properly calibrated so that the level of sound is audible to staff.

Rationale and Summary

A Critical Incident System (CIS) Report was submitted to the Director for a failure and breakdown of an essential service. During an identified period, on different units, the audible aspect of the resident-staff communication and response system failed. A review of the home's audit conducted on a specific date, by the Environmental Service Manager (ESM) indicated that several resident rooms on different floors were affected.

The ESM indicated that the call bell system when activated would alert staff as the light in the hallway above the resident room door would turn on, however the corresponding audible sounds failed. The ESM further indicated that this malfunction was a result of an issue identified with the power source for the system which failed resulting in glitches with the audible aspect of the system on the identified units.

Failure of the audible sound from the call bell system in the affected resident rooms on the affected units which posed an increased risk to the residents' safety, as staff were not alerted through this function to respond to the residents' needs.

Sources: CIS Report, and interview with ESM.

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COMPLIANCE ORDER CO #001 POLICY TO PROMOTE ZERO TOLERANCE

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]: FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

The licensee has failed to comply with FLTCA, 2021, s. 25 (1)

Specifically, the licensee shall:

1. Home to designate a clinical manager to re-train PA# 132, PSWs #133, #152, and #153 on the home's zero tolerance for abuse policy. Document the date of education provided; the name of the person who provided the education, and the names of the staff who have completed the education. Make this information available to inspectors upon request.
2. Clinical Manager to conduct unannounced, bi-weekly audits for one month for PA #132, PSWs #133, #152, and #153, on the understanding and retention of the home's zero tolerance for abuse policy. Document the audit date, who conducted the audit, names of the staff being audited and audit results. Make this information available to inspectors upon request.

Grounds

1) Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee failed to ensure that Program Aid (PA) #132 and RPN #133 followed the home's policy related to abuse allegations and follow-up.

Rationale and Summary

A CIS report was submitted regarding an allegation of abuse of a resident by PSW #154. A review of the home's investigation notes and interview with Programs Aid (PA) #132 indicated that on an identified date, PSW #154 approached a resident, grabbed an item away from the resident and threw it, while attempting to move the resident away without communicating to the resident. PA #132 further indicated that this left the resident shocked and fearful. PA #132 indicated that the resident and PSW #154 were in a residents' area when they left to report the allegation of abuse to RPN #133. RPN #133 acknowledged that PA #132 informed them of the event that took place, and that the resident was fearful. They further indicated that they instructed PSW #154 not to do this again and allowed them to then carry on completing the remainder of the shift.

PA #132 and RPN # 133 acknowledged that they did not separate the resident and alleged abuser. RPN #133 further acknowledged that they did not immediately report this incident, the home became aware of this a day later.

Review of the home's policy titled, "Abuse Allegations and Follow-up", last updated on March 2022, indicated that when a staff member receives report of abuse or observed anyone abusing a resident in any manner, staff will stop the abuse, separate the resident and the alleged abuser and ensure safety by immediately reporting.

Clinical Nurse Manager (CNM) #121 confirmed that PA #132 and RPN #133 did not follow the home's abuse allegations and follow-up policy.

Failure to comply with the zero tolerance of abuse policy, resulted in the possibility that this resident continued to be abused by PSW #154.

Sources: Home's investigation notes, Home's policy titled, "Abuse Allegations and Follow-up", last updated on March 2022, Interviews with PA #132, RPN #133 and CNM #121.

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2) Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee failed to ensure that PSWs #152 and #153 followed the home's policy related to abuse allegations and follow-up.

Rationale and Summary

A CIS report was submitted regarding an allegation of abuse towards a resident by PSW #154. A review of the home's investigation notes and interview with PSW #153 indicated that they had assisted PSW #154 with care for a resident in their room. They indicated that they witnessed PSW #154 yelling and being rough with the resident's care, which resulted in an incident and caused the resident to be fearful. PSW #153 further indicated that they informed PSW #152 on the same evening about the allegation of abuse as they did not feel right about it. PSW #153 acknowledged that they did not separate the resident and alleged abuser and ensure safety by immediately reporting the allegation of abuse. They confirmed that PSW #154 continued to provide care to the resident for the remainder of the shift. PSW #152 acknowledged that PSW #153 informed them of the allegation of abuse and that they did not report the allegation of resident abuse immediately.

Review of the home's policy titled, "Abuse Allegations and Follow-up", last updated on March 2022, indicated that when a staff member receives report of abuse or observed anyone abusing a resident in any manner, staff will stop the abuse, separate the resident and the alleged abuser and ensure safety by immediately reporting.

Acting Director of Care confirmed that PSWs #152 and #153 did not follow the home's abuse allegations and follow-up policy.

Failure to comply with the zero tolerance of abuse policy, resulted in the possibility that this resident continued to be abused by PSW #154.

Sources: Home's investigation notes, Home's policy titled, "Abuse Allegations and Follow-up", last updated on March 2022, Interview's with PSWs #152, #153, and Acting DOC.

[746]

This order must be complied with by

May 14, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.