Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

# Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée


**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 8, 2020 | 2019_530726_0012 | 014577-19, 019090-19, 019205-19 | 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 White Eagle Long Term Care Residence
138 Dowling Avenue TORONTO ON M6K 3A6

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

REBECCA LEUNG (726)

## 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 17, 18, 23 and 24, 2019 and off-site on December 19, 2019 and January 2, 2020.**

**The following Critical Incident System intakes were inspected during this inspection:**
**Log #014577-19 and Log #019090-19 related to prevention of abuse,**
**Log #019205-19 related to falls prevention.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Corporate Clinical Consultant, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.**

**During the course of the inspection, the inspectors reviewed residents' health records, home's training records, annual program evaluation, abuse incident analysis, policies and procedures, and observed staff to resident interactions.**

**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<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that there was a written plan of care that set out the planned care for resident #002.

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC) on an identified date related to a resident to resident physical abuse incident involving resident #001 and resident #002. Review of the CIS report indicated that resident #003 reported to RN #102 that resident #002 went with their assistive mobility device to an identified resident home area, and demanded resident #001 to go away because resident #002 wanted to sit in the specific location that was occupied by resident #001. Resident #001 then swung and hit resident #002 causing an injury to their identified body part.

In an interview, PSW #105 stated that at the time of the incident, they heard resident #003 calling for help. When they went to the identified resident home area, resident #003 told them that resident #002 used their assistive mobility device to bang on resident #001's chair repeatedly and told resident #001 to move away. Resident #001 then swung and hit resident #002. PSW #105 said that they called RN #102 for help and RN#102 came to assess the residents immediately.

Review of the identified note written by RPN #106 on an identified date after the CIS incident occurred, indicated that resident #002 was showing similar identified behaviour towards other residents if the resident sits in the chair that resident #002 liked or came near them. Resident #002 would bump their assistive mobility device onto the other resident’s wheelchair. Intervention used included staff to monitor the identified resident home area to ensure resident #002 did not initiate the identified behaviour towards other residents.

In an interview, PSW #103 stated that they observed resident #002 exhibiting the identified behaviours to other residents often. When they saw other residents sit in the specific chair in the identified resident home area that resident #002 always likes to sit in, they would redirect the other resident to sit on a different chair/spot before resident #002 went inside the identified resident home area. PSW #103 stated that they observed when resident #002 was inside the elevator and other residents tried to get in, resident #002 would push/hit the other resident out of the elevator with their assistive mobility device or swear sometimes. PSW #103 said they would try to take resident #002 by themselves to the elevator to prevent altercation with other residents. PSW #103 said that they

observed if other resident's specified body part while in wheelchair touched resident #002 by accident, resident #002 would kick the other resident back.

Review of resident #002's current care plan, the inspector was unable to find any written focus or interventions related to management of the above-mentioned identified behaviours exhibited by resident #002 towards other residents.

During the interviews, PSWs #103 and #107, RPN #106, RN #102 and the administrator acknowledged that a focus related to the triggers identified and interventions that were put in place to manage resident #002's identified behaviours should have been written in resident #002's care plan to provide directions to the staff.

The home has failed to ensure that there was a written plan of care that set out the planned care for managing resident #002's identified behaviours. [s. 6. (1) (a)]

***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 there is a written plan of care for each resident that sets out the planned care for the resident, to be implemented voluntarily.***

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**WN #2: 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 :**

1. The licensee has failed to ensure that resident #002 was protected from physical abuse by resident #001.

Under O. Reg. 79/10, s.2 (1), for the purpose of the definition, "physical abuse" means the use of physical force by a resident that causes physical injury to another resident.

A CIS report was submitted to the MLTC on an identified date related to a resident to resident physical abuse incident involving resident #001 and resident #002. Review of the CIS report and an identified report completed on an identified date by RN #102, indicated that on an identified date and time, RN #102 was called by resident #003 to attend to an identified resident home area. Upon arrival, RN #102 found resident #002 had an injury to an identified body part and resident #001 was sitting in the area. RN #102 was informed by resident #003 that resident #002 came with their assistive mobility device to the identified resident home area and demanded resident #001 to go away, because resident #002 wanted to sit in the specific chair that was occupied by resident #001. Resident #001 then swung and hit resident #002 causing an injury to their identified body part.

Review of an identified note written by RN #102 on an identified date and resident #001's care plan, indicated that close monitoring was initiated for the resident after the CIS incident occurred.

Review of an identified assessment for an identified date, indicated resident #001 was identified with a specified diagnosis with an identified functional impairment.

Review of the identified reports indicated that resident #001 was relocated to another unit a few days before the CIS incident occurred. Prior to the relocation, resident #001 initiated an identified behaviour towards a co-resident on an identified date, and another identified behaviour towards a different co-resident (#007) on an identified date. Review of an identified report indicated no injury was observed on resident #007.

Review of the care plan last review completed on an identified date, indicated that resident #001 had exhibited the identified behaviours towards co-residents before the CIS incident occurred. Triggers were identified and specific interventions were put in place.

Review of the resident's clinical records indicated that resident #001 was transferred to a specialty health facility on an identified date for assessment and management of the identified behaviours.

Review of an identified assessment for an identified date, indicated resident #002 was

identified with a specified diagnosis with an identified functional impairment.

Review of resident #002's care plan, indicated interventions were put in place for an identified responsive behaviour, no other specific behaviour was identified in the care plan prior to the CIS incident.

Review of an identified note written by RN #102 on an identified date, indicated that after the CIS incident occurred, resident #002 was assessed with an injury in a specified body part. Review of a specified note for an identified date, indicated that resident #002 was assessed by the physician after the CIS incident occurred with a physical injury to a specified body part noted. Specified treatments were prescribed. Review of an identified note for an identified date, the physician indicated that resident #002's injury had healed with no infectious concerns.

In an interview, RPN #106 stated that before resident #001 was relocated to their floor, they received report from the behavioural support nurse that resident #001 had exhibited some unpredictable identified behaviours and the staff needed to be present to monitor the resident when they were in the common resident home areas.

In an interview, PSW #105 stated that before resident #001 relocated to their floor, they received report that resident #001 might exhibit the identified behaviours sometimes. PSW #105 stated that at the time of the incident, they were the only PSW working on the floor, and was providing care to another resident in their room; they did not know resident #001 had gone out to the identified resident home area by themselves. When PSW #105 heard resident #003 calling for help, they went to the identified resident home area and resident #003 told them that resident #002 used their assistive mobility device to bang on resident #001's chair repeatedly and told resident #001 to move away; resident #001 then swung and hit resident #002. PSW #105 stated that they called RN #102 for help and RN #102 came up to assess the residents immediately.

In an interview, RN #102 confirmed the sequence of events of the incident as described in the CIS report and the other identified reports, and resident #001 was put on close monitoring immediately after the incident occurred.

During the interviews, the administrator stated that before relocating resident #001 to another floor, they were aware that resident #001 was fixated on resident #007. Whenever resident #007 was around, resident #001 would be triggered and exhibited the identified behaviour. The team then made the decision to transfer resident #001 to

another floor. The administrator stated that as they did not anticipate resident #001 to have altercations with the other residents other than resident #007, they discontinued the close monitoring for resident #001 after transferring resident #001 to another floor. After the CIS incident occurred, they re-started the close monitoring for resident #001 immediately and continued the intervention until resident #001 was transferred out to the specialty health facility. The administrator acknowledged that this CIS incident met the definition of resident to resident physical abuse.

The home has failed to ensure that resident #002 was protected from physical abuse by resident #001. [s. 19. (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 to ensure all residents are protected from abuse by anyone and are not neglected by the licensee or staff, to be implemented voluntarily.***

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**Issued on this 28th day of January, 2020**

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

**Original report signed by the inspector.**