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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 19, 2016	2015_247508_0019	032319-15	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

CHATEAU GARDENS NIAGARA LONG TERM CARE CENTRE
120 WELLINGTON STREET P.O. BOX 985 NIAGARA-ON-THE-LAKE ON L0S 1J0

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

ROSEANNE WESTERN (508), BERNADETTE SUSNIK (120), CATHY FEDIASH (214), GILLIAN TRACEY (130)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 26, 27, December 1, 2, 3, 4, 8, 9,10,11, 2015

**During this inspection all areas of the home were toured, lighting levels were measured, reviewed nursing staff schedules, relevant policies and procedures, lunch time meal services were observed, the home's complaint process, logs and investigation notes
were reviewed.**

Please Note: The following inspections were conducted simultaneously with this RQI: Critical Incidents (CI) #002708-14, #006205-14, #003645-15 related to resident to resident abuse, CI's #006201-14, #008038-14, #008081-15, related to resident fall with injury, CI #008113-15 related to resident injury, cause unknown, CI #015714 -15 related to unexpected death, complaints #008370-14 related to pain, skin and wound and continence, #008539-15 related to Personal Support Services, #029145-15 related to staffing levels, #029184-15 related to duty to protect, skin and wound and pain.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care(DOC), the Assistant Director of Care(ADOC), the Physiotherapist(PT), the Resident Assessment Instrument(RAI)Coordinator, Environmental Services Consultant, Maintenance Co-ordinator, Housekeeping and Laundry staff, registered staff, Personal Support Workers(PSW), President of Residents' Council, President of Family Council, residents and family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **10 WN(s)**
- **6 VPC(s)**
- **1 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	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. 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 did not ensure that all residents were protected from abuse by anyone.

Resident #301 was cognitively impaired and had known responsive behaviours which included aggression towards co-residents.

According to a Critical Incident submitted in March, 2015, resident #301 pushed resident #302, which resulted in an injury.

According to a Critical Incident submitted in September, 2015, resident #301 pushed resident #307, which resulted in an injury.

It was confirmed by the clinical record, staff interviews and the Critical Incident Submission (CIS) that residents #302 and #307 were not protected from abuse by resident #301.

This non- compliance was identified during CI Inspection 003645, which was conducted simultaneously with this RQI. (Inspector #130). [s. 19. (1)]

2. The licensee did not ensure that all residents were protected from abuse by anyone and ensure that residents were not neglected by the licensee or staff.

Resident #205 was admitted to the home on an identified date in 2015, with multiple health conditions and required a treatment intervention at an acute care facility on a regular basis. On an identified date in 2015, the Physician's notes indicate that the resident had been complaining of pain and the Physician ordered the resident medication.

The following day, staff from the acute care facility called the home to inform them that the resident was complaining of pain and the resident's treatment had to be discontinued due to this pain.

Ten days later, registered staff documented that the resident continued to complain of pain and the medication that had been ordered for this pain was having minimal effect. A note was left for the Physician to reassess the resident.

Three days later, the Physician reassessed the resident and increased the dosage of the medication. The following day, resident #205 refused to go for the treatment due to cramping. Registered staff observed that the resident had discolouration to the lower extremities.

For the next three days, resident #205 continued to complain of pain and continued to refuse treatments at the acute care facility due to this pain. Resident #205 had a fall while walking in their room and indicated to staff that their legs became weak. The resident was then transferred to hospital later that evening due to multiple health concerns. The resident underwent surgery while in hospital.

Resident #205 had appointed a family member as a Substitute Decision Maker (SDM) prior to the admission to the home. Staff regularly contacted the SDM with changes in the resident's plan of care.

Resident #205 had refused to go for treatments twice in one week due to pain. On both occasions, the staff did not ask the resident if the resident wanted their SDM involved in this decision which resulted in a significant decline in the resident's health condition. The SDM was not aware that the resident had not received the treatments until they had been informed by staff from the acute care facility.

It was confirmed during an interview with the Administrator on December 10, 2015, that staff failed to provide the resident with the treatment, care, services and assistance required for health, safety and well-being.

PLEASE NOTE: This non- compliance was identified during complaint inspection 003457 -15, which was conducted simultaneously with this RQI. (Inspector #508) [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (2) Where the Act or this Regulation requires the licensee to keep a record, the licensee shall ensure that the record is kept in a readable and useable format that allows a complete copy of the record to be readily produced. O. Reg. 79/10, s. 8 (2)

Findings/Faits saillants :

1. Where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any procedure, the licensee was required to ensure that the procedure was complied with.

As part of the organized program of laundry services under clause 15 (1) (b) of the Act, the licensee was required to ensure that procedures were developed and implemented to report and locate residents' lost clothing and personal items. A procedure was confirmed to have been developed by reviewing the policy and lost clothing form. The Administrator confirmed that the process was implemented as she had received several completed forms from health care staff in the past, but not for lost clothing for residents #008 or #012.

Resident #008 and resident #012 reported to LTC Inspectors #130 and #214 that several specific items of clothing were not returned to them once they were sent down to laundry in the month of November 2015. In December, 2015, both residents were interviewed by LTC Inspector #120 who confirmed the information previously reported and resident #008 further reported that some of their items were not labeled, however the health care aide sent the articles down to laundry without checking for labels. According to the Environmental Services Consultant, health care aides are required to check clothing for labels before sending the items for laundering. Both residents stated that they had reported the missing items to their health care aides a few days after they noticed the items did not return from laundry. Neither resident was escorted down to the laundry room to search for their items and neither received any feedback from the health care aides after making their reports. The laundry staff and Administrator interviewed were not aware that the identified residents had specific items missing. A search of the laundry room lost and found area was made and several items were observed to resemble the reported lost items and these items were pulled for later verification with the residents. The health care aides responsible for the residents' care did not complete the home's lost clothing form titled "Missing Clothing Report Form – N500-E-01.01.05" revised in February 2015 as required. The form was to be completed with details such as date, name of resident, description of the missing items and included direction for the staff to direct the person reporting the lost clothing to the lost and found area, search the home and laundry area, forward the report to management who would then in turn contact the resident with results of the search. [s. 8. (2)]

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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any procedure, the licensee is required to ensure that the procedure is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee did not ensure that the lighting requirements set out in the lighting table were maintained.

The home was built prior to 2009 and therefore the section of the lighting table that was applied is titled "In all other homes". An analogue light meter was used (Sekonic Handi Lumi with a +/-5% accuracy) to measure the lux levels in several resident bedrooms (private, semi and ward), common areas, several resident ensuite washrooms and corridors on both 2nd and 3rd floors. The meter was held a standard 30 inches above and parallel to the floor. Window coverings were drawn where possible in common spaces and in the resident bedrooms tested (to exclude natural light) and lights were turned on 5 minutes prior to measuring if found to be off. Outdoor conditions were cloudy during the measuring procedure. The shower, tub and dining rooms were not tested as they appeared adequately lit and equipped with adequate light fixtures. The minimum required lux level in resident bedrooms, bathrooms and lounges is 215. 28 lux.

A) Three resident ward bedrooms were measured on December 3, 2015 and were not all similarly equipped with the same light fixtures. Room #216 was equipped with troffer lights centrally and rooms #310 & 329 had a ceiling fan light. Rooms #310 & 329 were noted to be non-compliant. The rooms had a wall mounted over bed light fixture over each bed consisting of fluorescent tubes which were all turned on and exceeded the minimum required lighting level of 376.73 lux. However, when levels were tested at the foot of the bed, between the beds and at wardrobes, the levels were 100-150 lux.

B) Two private bedrooms were measured on December 3, 2015 and were not all similarly equipped with the same light fixtures. Room #312 had a surface mounted ceiling troffer light (with fluorescent bulbs) located near the room window and room #215 had a wall sconce near the window. When room #312 was measured, the amount of light was adequate directly under the light fixture, however the levels dropped as the meter was held at the foot of the bed, which was approximately 100 lux. When room #215 was measured, the lux levels were 50 at the foot of the bed, 75-100 at the wardrobe and 110 along both sides of the bed.

C) Two semi private bedrooms were measured December 3, 2015 and were not all similarly equipped with the same light fixtures. Rooms #318, 322 and 330 had no ceiling lights. The only light source was the over bed wall mounted lights (with fluorescent tubes) which were adequate for reading, however when the illumination level was tested at the sides of the bed, wardrobe and foot of bed, it was approximately 75-150 lux.

D) Corridors consisted of a drop ceiling, with troffer fixtures (flush mounted with fluorescent tube light bulbs) spaced 11 feet apart. Down the centre of each corridor, the lux was between 50-400 lux. Depending on the age of the bulbs, the lux varied directly under each light between 300-400 lux. The lux between the fixtures dropped dramatically due to the distance between the fixtures. A continuous and consistent lux of 215. 28 is required in corridors.

E) The lounge area located centrally on the 3rd floor was equipped with five light fixtures. Each fixture was not able to produce more than 100 lux of illumination. The central lounge on the 2nd floor was not measured, but appeared to be inadequately lit and would require assessment when natural light conditions could be controlled for.

F) Resident ensuite washrooms were compliant for the most part however, some were slightly under 215. 28 lux at the vanity such as in bathroom #215 where the fixture was not above the vanity. The majority of the bathroom were equipped with wall mounted light fixtures and incandescent bulbs and if replaced with a different type of bulb, would increase the illumination levels. [s. 18.]

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 lighting requirements set out in the lighting table are mainatained, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A review of resident #002's current written plan of care indicated under the restraint focus that the resident had a front closing seat belt when in their wheelchair for safety. A review of the Point of Care (POC) task's for this restraint that was completed on three identified days in November, 2015. The first task was if the resident was checked for safety and the second task was if the restraint was released, the resident repositioned and indicated the following:

On the first date reviewed, documentation indicated that the resident was checked at 1047 hours and not again until 1245 hours. Documentation later on this date indicated the resident was checked at 1635 hours and not again until 1950 hours.

Documentation indicated that the restraint was released and the resident was repositioned at 1635 hours and not again until 1950 hours.

On the second date reviewed, documentation indicated that the resident was checked at 1040 hours and not again until 1242 hours. Documentation later on this date indicated the resident was checked at 1603 hours and not again until 1902 hours.

Documentation indicated that the restraint was released and the resident was repositioned at 1603 hours and not again until 1902 hours.

On the third date reviewed, documentation indicated that the resident was checked at 1350 hours and not again until 1555 hours. Documentation later on this date indicated that the resident was checked at 1600 hours and not again until 2001 hours.

Documentation indicated that the restraint was released and the resident was repositioned at 1600 hours and not again until 2001hours.

An interview with the RAI Coordinator confirmed that the resident was checked hourly and that their restraint was released and the resident repositioned every two hours; however; not all of these actions taken had been documented. (214) [s. 30. (2)]

2. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's

responses to interventions were documented.

A review of resident #004's current written plan of care indicated under the restraint focus that the resident had a front closing seatbelt in wheelchair at all times for safety to prevent falls. A review of the Point of Care (POC) task's for this restraint was completed on two identified dates in November, 2015. The first task was if the resident was checked for safety and the second task was if the restraint was released, the resident repositioned and indicated the following:

On the first date reviewed, documentation indicated that the resident was checked at 1012 hours and not again until 1324 hours. Documentation later on this date indicated the resident was checked at 1601 hours and not again until 2106 hours.

Documentation indicated that the restraint was released and the resident was repositioned at 1601 hours and not again until 2106 hours.

On the second date reviewed, documentation indicated that the resident was checked at 1625 hours and not again until 2048 hours.

Documentation indicated that the restraint was released and the resident was repositioned at 1625 hours and not again until 2048 hours.

An interview with the RAI Coordinator confirmed that the resident was checked hourly and that their restraint was released and the resident repositioned every two hours; however; not all of these actions taken had been documented. (214) [s. 30. (2)]

3. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A review of resident #010's current written plan of care indicated under the restraint and falls focus that the resident had a front closing seat belt and table top when in their wheelchair for safety and to prevent leaning forward to much in their chair. A review of the Point of Care (POC) task's for these restraints was completed on three identified dates in November, 2015. The first task was if the resident was checked for safety and the second task was if the restraint was released, the resident repositioned and indicated the following:

On the first date reviewed, documentation indicated that the resident was checked at 1012 hours and not again until 1325 hours. Documentation later on this date indicated the resident was checked at 1600 hours and not again until 2106 hours.

Documentation indicated that the restraint was released and the resident was repositioned at 1600 hours and not again until 2106 hours.

On the second date reviewed, documentation indicated that the resident was checked at 1056 hours and not again until 1254 hours. Documentation later on this date indicated the resident was checked at 1357 hours and not again until 1551 hours.

On the third date reviewed, documentation indicated that the resident was checked at 0746 hours and not again until 1020 hours. Documentation later on this date indicated that the resident was checked at 1625 hours and not again until 2048 hours.

Documentation indicated that the restraint was released and the resident was repositioned at 1625 hours and not again until 2048hours.

An interview with the RAI Coordinator confirmed that the resident was checked hourly and that their restraint was released and the resident repositioned every two hours; however; not all of these actions taken had been documented. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessements, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Resident #205 had multiple health conditions and required a treatment intervention at an acute care facility on a regular basis. On an identified date in 2015, resident #205 was complaining of pain during this treatment and it was reported to staff at the home that the treatment could not be completed due to the pain.

Over a 17 day period in 2015, resident #205 had intermittently complained of pain in the lower extremities. Due to the pain, the resident refused to go to the acute care facility for their treatment. The resident told staff that the pain was severe. The resident was given an analgesic but continued to refuse to go for the treatments due to pain.

The resident had pain until the resident was transferred to hospital for further assessment and for the resident's treatment that was overdue.

On an identified date in 2015, a pain assessment using a clinically appropriate assessment instrument was completed which identified the resident as having no pain. Although the resident continued to complain of pain until the transfer to hospital, staff did not assess the resident's pain using a clinically appropriate assessment instrument during an 11 day period.

It was confirmed by the Assistant Director of Care on December 10, 2015, that when the resident's pain was not relieved by initial interventions, the resident's pain had not been reassessed using a clinically appropriate assessment instrument specifically designed for this purpose.

PLEASE NOTE: This non- compliance was identified during complaint inspection #003457-15, which was conducted simultaneously with this RQI. (Inspector #508) [s. 52. (2)]

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 when the resident's pain is not relieved by initial interventions, the resident is reassessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. As part of the organized program of housekeeping under clause 15(1)(a) of the Act, the licensee did not ensure that procedures were developed and/or implemented for cleaning of the home, specifically furnishings in resident rooms.

According to the home's "Housekeeping Services Procedure Guide" revised February 2015, no written procedure and frequency was available to direct housekeeping staff to clean or dust furnishings such as wardrobes. According to the Environmental Services Consultant, the housekeeping staff were required to follow a daily and monthly cleaning schedule. The daily schedule and duties required that floors, touch point surfaces and furnishings (low to medium height) be spot cleaned or dusted as necessary and that high dusting be completed monthly. The wardrobes were considered to be part of the "high" dusting schedule due to their height (just under 6 feet in height).

On December 2 & 3, 2015, a heavy accumulation of dust was noted on wardrobes in many resident bedrooms. These included but were not limited to rooms #321, 320, 310, 308, 307, 301, 236, 228, 227, 220 and 218. The amount of dust could be rolled off the top of the cabinet and was estimated that the cabinets were not cleaned for over one month.

A tour was completed with the Environmental Services Consultant of some of the above noted rooms who agreed that the amount of dust was heavy. When the rooms above were checked against the monthly cleaning schedule provided by the Consultant, which required the housekeeper to sign as completed, the following was noted:

* Room #220 cleaned Dec. 1st
* Room #321 and room #318 were both cleaned Dec. 3rd. When this room was checked in late afternoon on December 3, 2015, after the housekeeper cleaned the room, the wardrobes were heavily coated in dust.
* Room #304 cleaned on Nov 18th
* Room #302 cleaned on Nov 16th
* Room #310 cleaned on Nov 24th
* Room #308 cleaned on Nov. 21st.

The cleaning process or expected frequencies were not implemented by housekeeping staff and the written cleaning procedure for furnishings was not developed. [s. 87. (2) (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 procedures are developed and/or implemented for cleaning of the home, specifically furnishings in resident rooms, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. As part of the organized program of maintenance under clause 15(1)(c) of the Act, the licensee did not ensure that schedules or procedures were in place for remedial and preventive maintenance specifically related to the condition of flooring material and furnishings.

According to the home's maintenance policies, no specific written procedures were in place to guide maintenance or designated staff in conducting preventive maintenance duties related to the condition of floors and furnishings. The procedures would typically include a frequency of auditing or monitoring, how to identify conditions that would be acceptable or not acceptable and the necessary follow up actions required, if any. According to the Environmental Services Consultant, the maintenance personnel were required to complete routine audits and use a form developed for such a purpose. The audits provided for review were not on any specified forms and were missing dates of inspection or dates when follow up work was completed. Verification could not be made as to the extent of the work completed or what work was pending. A preventive inspection was completed for dressers, chairs and night tables for the 3rd floor on November 16, 2015 and many "x" marks noted in various resident rooms, however no

follow-up plans were included. No paper work was available for a similar audit on the 2nd floor.

A) On December 2 & 3, 2015, many of the resident night tables were found to be in rough shape, along the top front edge, where the particle board was quite exposed and could not be cleaned. Splinters could be acquired quite easily. These included night tables in but not limited to rooms #325, 321, 319, 317, 315, 312, 309, 308, 307, 301, 204, 211, 224, 218, 236 (dresser), 233 (dresser).

B) Many of the wooden chair legs located in resident rooms (320, 319, 318, 315, 302, 306, 308) were deeply scratched.

The Administrator was aware that some furniture would need to be replaced, but was not aware of the extent of the problem. No remedial plans were in place to schedule their repair or replacement at the time of inspection.

C) Flooring material was observed to be in poor condition (lifting, cracked, seams split) in the shower room on the 2nd floor near the dining room. The floor by the toilet in #205 was split (over 4 inches in length). The floor had lifted at the bathroom/bedroom transition in room #32. The floor in room #304 was split along both seams in the room. The floor was split near the bathroom entry in #306.

The home recently underwent a flooring replacement project in corridors and lounge spaces and some resident washrooms. However, the flooring issues observed above had not been captured in the audits provided and therefore no remedial plans were in place to schedule their repair at the time of inspection. [s. 90. (1) (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 that schedules or procedures are in place for remedial and preventive maintenance specifically related to the condition of flooring and furnishings, to be implemented voluntarily.

WN #8: 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:
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #305's right to to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately, was fully respected and promoted.

A) In the early morning on an identified date in April, 2015, resident #305 was observed by registered staff to have a significant change in their condition, including laboured breathing. Based on the nurse's assessment findings, the resident was transferred to hospital approximately an hour later. According to the progress notes, a note was left for staff to call the family in the morning. The home received a telephone call from the family several hours later to report that the hospital notified them and advised that the resident had a significant cardiac event and suggested the family call other family members to come to the hospital as the resident's prognosis was poor. The following afternoon, the hospital informed the home that the resident had passed away.

The ADOC and the clinical record confirmed the resident's POA was not notified immediately of the transfer to hospital.

This non compliance was identified as a result of Complaint Inspection 008539-15 which was conducted simultaneously with the RQI. (Inspector #130). [s. 3. (1) 16.]

WN #9: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A review of resident #401's clinical record indicated that in November, 2014, they sustained a fall that resulted in injury. A review of the Post Fall Analysis completed on that same day, indicated under assistive devices in use at the time of the fall, that a bed alarm was not in place. The Post Fall Analysis also indicated that the resident's care plan would be revised to include the use of a bed alarm. A review of the narrative Fall Resident Assessment Protocol (RAP) that was completed three days later, indicated that the resident currently used a bed alarm.

An interview with the ADOC indicated that the resident did have a bed alarm in place prior to this fall and that staff had not collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent and complemented

each other. (214) [s. 6. (4) (a)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) The plan of care for resident #300 indicated that the resident demonstrated responsive behaviours which included resistive behaviours and physical aggression. The plan of care directed staff to assess the resident prior to rendering care for potential aggressive behaviours. Interventions directed staff "If resistive, leave the resident safely and re-approach later".

In July, 2014, PSW #009 and #010 were assisting resident #300 into bed from their wheelchair, as the resident had refused to go to bed earlier in the evening.

According to the clinical record the resident demonstrated aggressive behaviours towards the staff while care was being rendered. The ADOC confirmed staff continued to render care to the resident despite the responsive behaviours. Staff did not leave the resident safely, walk away and reapproach, as specified in the plan of care.

This non-compliance was identified as a result of Critical Incident inspection: 002708-14, which was conducted simultaneously with the RQI. (Inspector #130) [s. 6. (7)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

A review of resident #001's Minimum Data Set (MDS) coding for a significant change in status that was completed on an identified date in 2015, indicated under section L.- Oral/Dental Status that the resident was coded as having some or all natural teeth lost and does not have or does not use dentures (or partial plates). A review of the Dental Care Resident Assessment Protocol (RAP) on the same date, indicated that the resident has some natural tooth loss and that their bottom dentures have gone missing since their last assessment. A review of the resident's written plan of care completed 13 days later, indicated that resident had full upper and lower dentures and wears them daily.

An interview with the back-up RAI Coordinator confirmed that the resident only has their upper dentures and that their plan of care was not reviewed and revised when their bottom dentures went missing (214) [s. 6. (10) (b)]

4. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

A review of resident #015's progress notes indicated that on and identified date in 2015, the resident sustained a fall resulting in a fracture to their arm. A review of the current written plan of care indicated under Skin/Pressure Ulcer Risk that staff were to ensure that the resident is wearing sling at all times appropriately. An observation of the resident on December 9, 2015, indicated that resident was not wearing their sling. An interview with staff # 011 and #012 as well as a review of the resident's progress notes, indicated that the resident no longer wore their sling as they had been refusing to wear it. The staff interviewed confirmed that that the resident's plan of care was not reviewed and revised when their care needs changed. (214) [s. 6. (10) (b)]

5. The licensee has failed to ensure that when the resident was reassessed the plan of care was reviewed and revised when the resident's care needs changed.

Resident #205 had multiple health conditions and required a treatment intervention at an acute care facility on a regular basis. On an identified date in 2015, resident #205 was complaining of pain in the lower extremities during a treatment and it was reported to staff at the home that the treatment could not be completed due to the pain.

Over a 17 day period in 2015, resident #205 had intermittently complained of pain in the lower extremities. Due to the pain, the resident refused to go to the acute care facility for their treatment. The resident told staff that the pain was severe. The resident was given an analgesic but continued to refuse to go for the treatments due to pain.

The resident's plan of care indicated that the resident had identified their pain level at 0. The location of the resident's pain was in a different area of the body then where the resident was currently complaining about. A review of the resident's progress notes indicated that the resident was complaining of severe pain in the lower extremeties, however, the resident's plan of care had not been revised to indicate this.

It was confirmed by the Assistant Director of Care on December 10, 2015, that the resident's plan of care had not been reviewed and revised when the resident's care needs changed.

PLEASE NOTE: This non- compliance was identified during complaint inspection 003457 -15, which was conducted simultaneously with this RQI. (Inspector #508) [s. 6. (10) (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

A) The Quarterly MDS Assessment completed for resident #007 in June, 2015, was coded zero for bowel continence, indicating they were continent of bowel. The Quarterly MDS Assessment completed in September, 2015 was coded one, indicating the resident was usually continent of bowel. The RAI Coordinator confirmed the resident was not assessed using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence when the resident's continence status changed. (Inspector #130). [s. 51. (2) (a)]

Issued on this 8th day of February, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ROSEANNE WESTERN (508), BERNADETTE SUSNIK (120), CATHY FEDIASH (214), GILLIAN TRACEY (130)
Inspection No. / No de l'inspection :	2015_247508_0019
Log No. / Registre no:	032319-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 19, 2016
Licensee / Titulaire de permis :	Chartwell Master Care LP 100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1
LTC Home / Foyer de SLD :	CHATEAU GARDENS NIAGARA LONG TERM CARE CENTRE 120 WELLINGTON STREET, P.O. BOX 985, NIAGARA-ON-THE-LAKE, ON, L0S-1J0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LORRAINE KOOP

To Chartwell Master Care LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall:

1. ensure that residents are protected from abuse by anyone, specifically by residents who exhibit aggressive behaviours towards co-residents.

2. ensure that residents are not neglected by staff when there is a change in the resident's condition.

3. ensure that residents who have others involved in assisting them in making decisions related to their plan of care are consistently provided the opportunity to involve that person as per the wishes of the resident.

Grounds / Motifs :

1. The licensee did not ensure that all residents were protected from abuse by anyone and ensure that residents were not neglected by the licensee or staff.

Resident #205 was admitted to the home on an identified date in 2015, with multiple health conditions and required a treatment intervention at an acute care facility on a regular basis. On an identified date in 2015, the Physician's notes indicate that the resident had been complaining of pain and the Physician ordered the resident medication.

The following day, staff from the acute care facility called the home to inform them that the resident was complaining of pain and the resident's treatment had to be discontinued due to this pain.

Ten days later, registered staff documented that the resident continued to

complain of pain and the medication that had been ordered for this pain was having minimal effect. A note was left for the Physician to reassess the resident.

Three days later, the Physician reassessed the resident and increased the dosage of the medication. The following day, resident #205 refused to go for the treatment due to cramping. Registered staff observed that the resident had discolouration to the lower extremities.

For the next three days, resident #205 continued to complain of pain and continued to refuse treatments at the acute care facility due to this pain. Resident #205 had a fall while walking in their room and indicated to staff that their legs became weak. The resident was then transferred to hospital later that evening due to multiple health concerns. The resident underwent surgery while in hospital.

Resident #205 had appointed a family member as a Substitute Decision Maker (SDM) prior to the admission to the home. Staff regularly contacted the SDM with changes in the resident's plan of care.

Resident #205 had refused to go for treatments twice in one week due to pain. On both occasions, the staff did not ask the resident if the resident wanted their SDM involved in this decision which resulted in a significant decline in the resident's health condition. The SDM was not aware that the resident had not received the treatments until they had been informed by staff from the acute care facility.

It was confirmed during an interview with the Administrator on December 10, 2015, that staff failed to provide the resident with the treatment, care, services and assistance required for health, safety and well-being.

PLEASE NOTE: This non- compliance was identified during complaint inspection 003457-15, which was conducted simultaneously with this RQI. (Inspector #508) [s. 19. (1)]

(508)

2. The licensee did not ensure that all residents were protected from abuse by anyone.

Resident #301 was cognitively impaired and had known responsive behaviours which included aggression towards co-residents.

According to a Critical Incident submitted in March, 2015, resident #301 pushed resident #302, which resulted in an injury.

According to a Critical Incident submitted in September, 2015, resident #301 pushed resident #307, which resulted in an injury.

It was confirmed by the clinical record, staff interviews and the Critical Incident Submission (CIS) that residents #302 and #307 were not protected from abuse by resident #301.

This non- compliance was identified during CI Inspection 003645, which was conducted simultaneously with this RQI. (Inspector #130). [s. 19. (1)] (130)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 19th day of January, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Roseanne Western

Service Area Office /
Bureau régional de services : Hamilton Service Area Office