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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 13, Jul 13, 2016	2016_250511_0010	017143-16	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

ROBIN MACKIE (511), IRENE SCHMIDT (510a), KELLY CHUCKRY (611), KERRY ABBOTT (631)

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): June 13, 14, 15, 16, 17, 21, 22, 23, 24, 2016.

During this Inspection the following critical incidents were also inspected: 029594-15 CIS Notification (resident to resident altercation), 003941-16 CIS Notification (safe and secure home), 004309-16, 009210-16 CIS Notifications (resident to resident altercations), 009853-16 CIS Notification (improper transfer of resident) and 013270-16 CIS Notification (resident to resident altercation). During this Inspection a follow up to Order #1 LTCHA, 2007 S.O. 2007,c.8, s.19 was also completed.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Social Worker (SW), Food Services Manager (FSM), Environmental Services Manager (ESM), staffing clerk, dietary aides, registered staff including Registered Nurses (RN) and Registered Practical Nurses (RPN), Personal Support Workers (PSW), Occupational Therapist (OT), Physiotherapist (PT), residents and family members.
In the course of this inspection the Inspectors observed the provision of resident care, meal service, reviewed applicable resident records and applicable licensee policy and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 19. (1)	CO #001	2015_247508_0019	611

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Resident #021 had cognitive impairment. During stage one of the RQI, the resident reported their dental condition. On further questioning, the resident reported to the MOHLTC Inspector and registered staff #101 that their dental condition was present since admission to the home. The resident expressed a strong desire to have their

dental condition corrected, to facilitate eating. Review of the clinical record revealed that:
1) the initial assessment reported the resident had a different dental condition than stated above,
2) the care plan indicated the resident had a dental condition as outlined in the initial assessment, and
3) the kardex was consistent with the care plan.
The care set out in the plan of care was not based on an assessment of the resident and the needs and preferences of that resident. (510a) [s. 6. (2)]

2. The licensee has failed to ensure that staff and others involved in different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care.

Resident #042 had cognitive impairment. A resident assessment protocol (RAP) in 2016 reported the resident had some natural teeth with dentures. It was confirmed by the ADOC that the document the home referred to as the care plan, as well as the Kardex, directed that the resident wore their dentures.
On a day in 2016, at 1155 hours, the resident was observed to be not wearing dentures. Personal support staff #138 confirmed they had provided care to the resident and that the resident would not wear their dentures. PSW #138 further reported they had been advised the resident would not wear their denture by the lead PSW for that team. Registered staff #101, who was party to this conversation, confirmed they had not been advised that the resident would not wear their dentures. Staff involved in different aspects of care of the resident had not collaborated with each other in the development and implementation of the plan of care. (510a) [s. 6. (4) (b)]

3. The licensee has failed to ensure that the resident, the Substitute Decision Maker, if any, and the designate of the resident/SDM were provided the opportunity to participate fully in the development and implementation of the plan of care.

Resident #014 had an OT referral completed by the Restorative Aide in 2015. The referral was completed and a orthotic device was suggested. The OT referral was completed in the same month in 2015, and recommended the orthotic device be worn for a specified period of time.

The orthotic device was applied on resident #014 in the same month in 2015. The OT referral and suggestions were not discussed with the resident's Substitute Decision Maker (SDM) and the SDM was not provided the opportunity to participate fully in the

development and implementation of the plan of care.

The ADOC confirmed that resident #014's SDM was not provided the opportunity to participate fully in the development and implementation of the plan of care. [s. 6. (5)]

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

A Critical Incident Report was submitted to the Ministry of Health and Long Term Care on a day in 2016 for an incident of improper/incompetent treatment of resident #006 that resulted in harm or risk of harm. A review of resident #006 clinical record and Critical Incident Report identified the resident was transferred by two PSW's without using a mechanical lift on a specific date in 2016. During this transfer the resident's sustained and injury that required treatment. A review of the resident's plan of care for the same period indicated the resident was to be transferred using a mechanical lift with two staff for all transfers. The resident was documented to be unable to safely weight bear. Interview with the DOC confirmed the licensee had not ensured the care set out in the plan of care was provided to the resident as specified in the plan when they were transferred without using a mechanical lift. [s. 6. (7)]

5. The licensee has 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 care set out in the plan of care had not been effective.

Resident #301 was cognitively impaired and had identified responsive behaviours. The clinical record identified the responsive behaviour, triggers for this behaviour and interventions. The progress notes reported that resident #301 demonstrated this responsive behaviour when they were triggered by resident #303's action. This resulted in an altercation between the residents that resulted in a fall to resident #303.
The document the home referred to as the care plan contained an intervention that was put in place to prevent resident #301 behaviour from being triggered. Registered staff #103 confirmed that staff had implemented the intervention in the past and it had not worked in preventing the responsive behaviour. The care plan was updated after the altercation between resident #301and #303 despite knowing the intervention had not been successful in the past. The ADOC confirmed the above. The care plan was not revised when care set out in the plan of care had not been effective. [s. 6. (10) (c)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

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. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, instituted or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee failed to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

A breakfast meal service observation took place on June 14, 2016. Near the end of the meal service a review of the "Food Temperature" book was reviewed. The temperatures for puree bread, hot cereal, eggs, and puree eggs were blank with no temperature entries identified. An interview with staff #132 revealed the temperatures were taken at the start of the meal service but were not yet documented. Staff #132 further indicated the temperatures were easy to remember when taken, as there were only a few items. The temperatures were verbally communicated as the puree bread 160 degrees, hot cereal as 192 degrees, eggs as 183.7 degrees, and puree eggs as 184 degrees.
A copy of the "Food Temperature" log book for the week of June 13 to 19, 2016 was obtained and the temperatures for the breakfast meal service on June 14, 2016 were documented as the puree bread 160 degrees, hot cereal as 190 degrees, eggs as 184.7 degrees, and puree eggs as 182 degrees.
The home had a policy in place entitled Food Temperature (LTC-CA-WQ-300-04-02) with a last revision date of January 2015. This policy described the procedure for taking food temperatures, and identified that the Food Service Worker would take and record the food temperature once food has been placed on/in the hot top/steam table, on the Food Temperature Sheet. Staff #132 confirmed they had not documented the temperatures as identified in the policy which resulted in inconsistencies with the temperature taken versus the temperature documented.
An interview conducted with the Food Services Manager confirmed that the home's policy entitled Food Temperature was not complied with. [s. 8. (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 the Licensee's Food Temperature (LTC-CA-WQ-300-04-02) policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents had a screen and could not be opened more than 15 centimetres.

An immediate Order was issued to the licensee during the Resident Quality Inspection on June 13, 2016, for O.Reg.79/10, s.16 and was complied on the same date.

A) On Monday June 13, 2016, at 0950 hours, during the initial Resident Quality Inspection tour, it was observed that 5 windows in the home opened to measure 20 centimetres (cm). These windows were located in the sun rooms on level two and three, and in resident rooms #220 and #232. This was confirmed by the Administrator who also confirmed that it would be possible for residents to squeeze through the openings at the sill level of these windows, presenting a risk to residents.
Windows accessible to residents and opening to the outside opened more than 15 cm., presenting risk to residents. (510a)

B) A review of a Ministry of Health Critical Incident Report, dated in 2016, indicated resident #400 had exited the home through an unsecured opening. Resident #400 had been recently admitted to the home prior to the incident. A review of the clinical record indicated the resident ambulated independently and had a known behaviour of wandering with exit seeking.
Staff #140 had stated they were the first person to observe the resident outside of the home on the specific date in 2016. A review of the clinical record indicated that two staff immediately ran to the resident to ensure the safety of the resident while Emergency Medical Services were notified. The resident was sent to the hospital for further assessment. An interview with two staff members #139 and #140, that had worked at the time of the elopement, indicated the resident had been under close supervision for the previous 48 hours due to their exit seeking behaviour. Staff #140 confirmed they had just observed the resident wander in and out of other resident rooms approximately 15

minutes prior to the incident. Staff #140 stated they witnessed the resident when they were approximately five to six feet outside of the home.

A review of purchase orders and an Installation document, dated in 2014, indicated a window supply company had installed seven new windows. This document confirmed that each window, at the time of installation, had sash restrictors installed that permitted only minimal openings of the windows and prevented each new window from opening into a full up position.
On further review of the licensee's internal investigation notes and on an interview with the Administrator, it was stated that parts of the window frame were alleged to have been broken by the resident however there were no window sash restrictors on the window or located in the room at the time of the incident. Interview with the Administrator confirmed that without the sash restrictors in place the window could be opened to a full up position as observed by staff #140 on the night of the incident. The Administrator confirmed the home had investigated the reason for the absence of the sash restrictors on this window. It was confirmed by Inspector 511, on June 21, 2016, that the new windows identified as being installed in 2014, that were the same make as the window that resident #400 had eloped from, had screens and sash restrictors secured in place. (511)

The Administrator confirmed the new windows were inspected after the incident, to ensure screens and sash restrictors were in place and secured. The Administrator confirmed the home extended the window audit to further inspect all windows in the home and a full audit of all windows were completed by the home on February 8, 2016, February 12, 2016, and July 13, 2016. A review of the home's Operational Plan for Window replacement, which had been submitted to the MOHLTC, was reviewed with the Administrator and this Inspector. The Administrator confirmed the home's plan was to replace 33 older style windows by the end of July 2016. [s. 16.]

WN #4: 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 has failed to ensure that each 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 that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

A) Resident #041 was admitted to the home in 2014. Their ON- Bladder Continence assessment, completed on a specific date in 2014, indicated they were usually continent of their bladder with incontinent episodes occurring once a week or less. They were described as having urge incontinence in this assessment instrument. On a specific date in 2015, their Minimum Data Set (MDS) assessment indicated they had deteriorated from being usually incontinent to occasionally incontinent where they experienced bladder incontinence more than two times a week but not daily. On a later date in 2015, their MDS assessment revealed another deterioration in their bladder incontinence when they went from occasionally incontinent to being incontinent daily, but still had some control present (e.g. on day shift). The most recent MDS assessment reviewed in 2016 indicated the resident now had inadequate control of their bladder with multiple daily episodes of bladder incontinence. A review of the clinical record did not indicate another ON- Bladder Continence assessment had been completed since the first assessment in 2014.
Interview with the MDS-RAI (Resident Assessment Instrument) coordinator confirmed the ON- Bladder Continence assessment was the clinically appropriate assessment instrument that the home used for assessment of resident's incontinence.
Interview with the MDS-RAI coordinator confirmed the licensee failed to ensure the resident's continence was assessed, using a clinically appropriate assessment tool that

was specifically designed for assessment of incontinence, when the home's ON- Bladder Continence assessment was not completed when the condition or circumstances of the resident required.

B) A review of the clinical record indicated resident # 007 was admitted to the home in 2015, with a medical device in place. The resident's MDS assessment, completed in 2015, had indicated the resident's medical device assisted the resident in maintaining their continence. The treating doctor saw the resident on a later date in 2015, and a decision to remove the medical device was ordered. The doctor also documented that following the removal of the device, nursing interventions would need to remain in place to ensure the resident would not develop a complication related to the removal. After the removal of the medical device, one month later, the resident had been documented to be frequently incontinent of their bladder daily. Further review of the clinical record for resident #007, who was incontinent post removal of their medical device, did not include an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Interview with the MDS-RAI coordinator confirmed the removal of the medical device was a condition or circumstance that would have indicated an assessment be conducted using the home's ON-Continence Bladder assessment, a clinically appropriate assessment tool, in order to identify causal factors, patterns, type of incontinence and the potential to restore function with specific interventions for resident #007. [s. 51. (2) (a)]

WN #5: 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 for each resident that demonstrated responsive behaviours, (c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Resident #400 was admitted to the home in 2016, with a cognitive impairment. A review of the clinical record indicated the resident ambulated independently and had a known behaviour of wandering with exit seeking. The resident was placed on a documented 24 hour monitoring plan that described the resident's activity and response every 30 minutes. On a specific date in 2016 the resident eloped from the Long Term Care home. Interview with staff members #140 and #139, that were working at the time of the elopement, confirmed they had observed the resident approximately 15 minutes earlier wandering the hallways and going in and out of co-residents' rooms. A review of the 24 hour monitoring plan and the progress notes indicated 19 episodes in 2016 where there were absences in the documentation.

A review of the staffing schedule and interview with the home's staffing clerk confirmed staff had provided the one to one care on the 19 days that the missing documentation was identified. Interview with the DOC and ADOC confirmed the licensee failed to ensure the resident's response to the one to one interventions were documented. [s. 53. (4) (c)]

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that they sought the advice of the Family Council when they developed and carried out the satisfaction survey, and when they acted on its results.

At the time of the Resident Quality Inspection (RQI) the home had a Family Council in place. A telephone interview conducted with the President of Family Council revealed that the home did not seek the advice of the council in the development and carrying out of the satisfaction survey. A review of the minutes from the council further revealed this to be the case.

An interview conducted with staff #141, and a subsequent interview conducted with the Administrator confirmed the home did not seek the advice of Family Council in the development and carrying out of the satisfaction survey. [s. 85. (3)]

Issued on this 14th day of July, 2016

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

Original report signed by the inspector.