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 sions 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
Dec 7, 2016	2016_533115_0034	029151-16	Resident Quality Inspection

Licensee/Titulaire de permis

MERITAS CARE CORPORATION
567 VICTORIA AVENUE WINDSOR ON N9A 4N1

Long-Term Care Home/Foyer de soins de longue durée

CHATEAU PARK LONG TERM CARE HOME
2990 B RIVERSIDE DRIVE WEST WINDSOR ON N9C 1A2

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

TERRI DALY (115), ALICIA MARLATT (590), ALISON FALKINGHAM (518)

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 21, 22, 23, 24, & 25, 2016

The following intake was completed within the RQI:
Critical Incident 2712-000013-16/Log #032774-16 related to a fall.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Dietary Manager, the Maintenance Manager, three Registered Nurses, three Registered Practical Nurses, six Personal Support Workers, one Activity Aide and a Residents' Council representative, residents and their families.

The inspectors also toured the home, observed medication administration, medication storage, reviewed relevant clinical records, policies and procedures, meeting minutes, schedules, posting of required information, observed the provision of resident care, resident staff interactions, and the general maintenance, cleanliness, safety and condition of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Skin and Wound Care

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Inspector #518 observed an alteration in skin integrity for resident #022.

Review of the home's policy titled "Skin Care Management Program" reviewed December 2015, revealed that:
HCA/PSW staff members are to "Complete and document a skin care assessment daily. Report changes in skin condition to registered staff for further assessment and for completion of assessment form PRN".

During an interview with RPN #104 she shared that the PSW's were to complete daily skin assessments on residents and document them in Point of Care (POC). If they had found any alteration in skin integrity they were to report to the registered staff, who would then complete an assessment. The registered staff member was to complete an assessment and an incident report about the alteration for follow up monitoring. At that time the inspector and RPN #104 observed the alteration in skin integrity together. RPN #104 indicated that there was no documentation related to the alteration.

A review of the progress notes for a two week period, revealed no documentation related to the alteration in skin integrity for resident #022.
Review of the POC documentation, revealed that the daily skin care assessments were completed, but no documentation related to the alteration in skin integrity was completed by the PSW staff.

During an interview with DOC #101 she stated that alterations in skin integrity were to be documented in POC by the PSW's and reported to registered staff for follow up documentation and care. She indicated that the policy mentioned above outlines the PSW's expectations.

The severity of this issue was determined to be a level 2 which is a minimal risk or potential for actual harm, and the scope a level 1 which is isolated. The home's compliance history for this area of legislation is a level 2 which is one or more unrelated non compliance in the last three years. [s. 8. (1) (a),s. 8. (1) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that documentation for use of a physical device to restrain a resident included release of the device and repositioning.

Resident #003 was observed during Stage 1 of the RQI, using a restraint.
Resident #003 had an order for use of a restraint.
A review of the Point Click Care (PCC) progress notes indicated that the restraint was in place.
A review of Point of Care (POC) flow sheets revealed that documentation for the restraint, was initiated.

A review of the home's policy Restraint Program (minimizing), reviewed May 2016, indicated:
Recording Restraint/PASD in POC:
Purpose:
"Our purpose is to provide required documentation and evidence of the hourly safety check, use/removal of restraint/PASD, repositioning and re-application of any restraint/PAS in use within the facility."

Roles and Responsibilities
HCA/PSW
"Monitors resident's safety every 1 hour or more frequently and every 2 hours for repositioning or more frequently per care plan."

During an interview with PSW #114 she indicated that resident #003 used a restraint, that the resident was checked hourly and repositioned every two hours. PSW #114 stated that documentation was completed as a task in POC under restraint check and repositioning.

During an interview with the Director of Care #101 she stated that the documentation for this restraint was not completed per the home's policy when the restraint was initiated.

The severity of this issue was determined to be a level 2 which is a minimal risk or potential for actual harm, and the scope a level 1 which is isolated. The home's compliance history for this area of legislation is a level 2 which is one or more unrelated non compliance in the last three years. [s. 110. (7) 7.]

Issued on this 3rd day of January, 2017

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

Original report signed by the inspector.