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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 12, 2014	2014_257518_0022	L-000509-14	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

THE ROYAL OAK LONG TERM CARE CENTRE
1750 Division Road North, KINGSVILLE, ON, N9Y-4G7

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

ALISON FALKINGHAM (518), ALICIA MARLATT (590), PATRICIA VENTURA (517), ROCHELLE SPICER (516)

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): May 5-9, 12-14, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, two Assistant Directors of Care, the Environmental Services Manager, the Maintenance Personnel the RAI Coordinator, three resident family members, six Registered Staff members and ten Personal Support Workers.

During the course of the inspection, the inspector(s) reviewed resident clinical records, the homes policies and procedures, observed general resident care, observed medication administration and several meal services.

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
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is a safe and secure environment for all residents.

A resident was not operating the wheelchair safely.

The Director of Care confirmed that the resident is to operate the wheelchair safely.

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 relating to ensuring that the home is a safe and secure environment for all its residents., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that,
(a) there is an organized program of housekeeping for the home; 2007, c. 8, s. 15 (1).
(b) there is an organized program of laundry services for the home to meet the linen and personal clothing needs of the residents; and 2007, c. 8, s. 15 (1).
(c) there is an organized program of maintenance services for the home. 2007, c. 8, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

[redacted]

A resident bed was observed by Inspector and Administrator.
There was a 6" gap between the mattress and head of bed.

The Administrator noted the bed did not have the bolster at foot of bed in place.
The bolster is used to prevent gaps between the mattress and the head and/or foot of bed.

The Administrator confirmed the gap at head of bed and that the bolster should have been in place.
The Administrator put bolster in place and there was no longer a gap at head of bed.
[s. 15. (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 related to ensuring that steps are taken to prevent resident entrapment in all zones of potential entrapment., to be implemented voluntarily.

WN #3: 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. (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 care set out in the plan of care was provided to the resident as specified in the plan.

The plan of care provided a schedule for the application of [redacted].

The resident was not wearing [redacted] at the scheduled time as outlined in the plan of care.

A registered staff member verified that the resident should be wearing [redacted] at this time. [s. 6. (7)]

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

A resident care plan indicates that razors and metal hangers should not be left in the residents possession for safety reasons.

Progress notes from indicate that a Personal Support Worker placed metal hangers in resident a resident closet.

It was confirmed by the Assistant Director of Care that it is the expectation that staff know and follow the directions in the residents are care plan. [s. 6. (7)]

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

The residents current plan of care stated the residents level of continence as: continent.

A PSW revealed the resident had bowel incontinence.
Bowel incontinence was documented on the residents daily flow sheet.

The RAI Coordinator confirmed the residents plan of care should have been updated when the resident developed bowel incontinence. [s. 6. (10) (b)]

WN #4: 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 failed to ensure that any plan, policy, procedure, strategy or system instituted or otherwise put in place is: (a) in compliance with and is implemented in accordance with all applicable requirements under the act, and (b) is complied with. r. 8. (1) (b)

There was an incident of violence and aggression by a resident [redacted]

The homes policy LTCE-CNS-G-16 states that following an aggressive incident a responsive episode debrief be completed and documented under the Assessments.

A responsive behaviour episode debrief was not completed following this incident.

It was confirmed by the Assistant Director of Care that it would be the expectation that the Responsive Behaviour Policies be followed and the Responsive debrief assessment be completed. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure the homes policy was complied with.

The Corporate policy No: LTCE-CNS-G-14 identifies actions to be taken when a resident operates a wheelchair unsafely.

Progress notes documented [redacted] of unsafe wheelchair operation by a resident.

The resident did not receive a written letter from the team outlining the occurrence and strategies to prevent recurrence within 3 working days of the incident.

The Director of Care confirmed the policy regarding safe operation of a wheelchair was not followed. [s. 8. (1)]

WN #5: 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 opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

The window in the community laundry room near the Oak wing was noted to have no window stopper. The window was able to be opened greater than 15 centimeteres.

The Administrator confirmed this opening greater than 15cm. Maintenance was notified and corrective action was taken. [s. 16.]

WN #6: 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 failed to ensure that for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified.

The progress notes reveal in many instances that there are ongoing [redacted] issues between two residents. One resident is a trigger for angry and aggressive outbursts.

The residents care plan does document that there is anger towards the other resident, however this is not listed with the other triggers in MDS.

It was confirmed by the Director of Care that unsettled relationships should be listed as a trigger in the residents care plan and documented in MDS. [s. 53. (4) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances at the home are kept inaccessible to residents at all times.

An inspectors noted an unattended housekeeping cart with hazardous cleaning solution.

A housekeeping staff member confirmed that the cleaning cart should have been in her view and locked at all times. [s. 91.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The Licensee failed to ensure that steps are taken to ensure the security of the drug supply, including ensuring that all areas where drugs are stored shall be kept locked at all times, when not in use.

An unlocked, unattended medication cart was noted in the hallway in a home area. The RPN responsible for the medication cart did not have the unlocked medication cart within view.

The RPN confirmed the medication cart was unlocked and not within her view.

This was further confirmed with the Director of Care by Inspector #518 that it is the expectation that all medication carts are kept locked when not in use. [s. 130. 1.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The Licensee failed to ensure that all staff participate in the implementation of the infection control program.

A urinary catheter bag for resident #418 was noted to be directly on the floor.

A PSW staff member confirmed the urinary drainage bag should not be on the floor and removed the bag from the floor and attached it to the bed.
This was further confirmed with the Administrator by Inspector #518 that it is the expectation that urinary catheter bags not be placed on the floor. [s. 229. (4)]

Issued on this 12th day of June, 2014

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