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
Apr 16, 22, 2015	2015_256517_0006	L-001806-15	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

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

PATRICIA VENTURA (517), ALICIA MARLATT (590), 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): February 25, 26, 27, 2015 and March 2, 3, 4, 5, 6, 9 &10, 2015

Complaints Log#002349-15 & Log#001245-15 were inspected during this Resident Quality Inspection.
The following Critical Incidents were inspected during this Resident Quality Inspection:
Log#007953-14 - CI2939-000040-14
Log#009490-14 - CI2939-000043-14
Log#009780-14 - CI2939-000044-14
Log#000077-15 - CI2939-000001-15
Log#001290-15 - CI2939-000003-15
CI2939-000006-15

During the course of the inspection, the inspector(s) spoke with the Manager of Regional Operations, the Administrator, two Directors of Care, two Assistant Directors of Care, the Nurse Consultant, the Scheduling Manager, the Environmental Services Manager, the Food Services Manager, the Recreation Manager, the RAI Coordinator and BSO Lead, the Registered Dietitian, the President of Resident Council, two Registered Nurses, eight Registered Practical Nurses, fourteen Personal Support Workers, one Health Care Aide, one Maintenance Staff, two Housekeepers and one Activity Aide.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
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
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

6 WN(s)
5 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 LTCHA, 2007 S.O. 2007, c.8, 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. (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).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care for resident #21 was based on an assessment of the resident and the resident's needs and preferences with regard to personal care items.

Interviews with two Personal Support Workers, one Registered Practical Nurse and the Director of Care revealed the resident's personal care items were missing for over six months and the resident did not presently have them available for use.

Health record review for resident #21 revealed the resident's written plan of care in Point Click Care and the resident's Kardex in Point of Care indicated the resident used the personal care items and directed the staff to ensure these were in place daily.

The Director of Care confirmed the plan of care for resident #21 was not updated when the resident's personal care items were no longer available to the resident. The Director of Care also verified the resident's plan of care should be based on the resident's current needs and preferences. [s. 6. (2)]

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

Health record review for resident #33 revealed the resident required skin treatments.

Documentation entries in resident #33’s progress notes indicated this care was not provided to resident #33 on two separate days.

The Administrator and the Director of Care confirmed this care was required and was not provided to resident #33 on the two separate days. The Administrator shared that staff members were required to make an alternate plan to ensure all required care was provided to the resident if the assigned staff member was unable to deliver the care and that this wasn't done.

The Administrator confirmed the expectation that all care required by a resident was provided as specified in the resident's plan of care. [s. 6. (7)]

3. 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 written plan of care for resident #21 identified a strategy for staff to initiate when the resident exhibited a specific behaviour.

Interviews with two Personal Support Workers revealed that when the resident exhibited the specific behaviour, the staff member did not implement the identified strategy.

The Personal Support Worker verified the plan of care for the resident included an identified strategy when the resident exhibited a specific behaviour. The staff member also confirmed care was not provided to the resident as specified in the plan.

The Administrator and the Director of Care confirmed the same and verified the expectation that care was provided to residents as per their plan of care. [s. 6. (7)]

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 the plan of care for residents is based on an assessment of the residents and the resident's needs and preferences, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Interview with a maintenance staff member revealed all beds where bed rails were used needed to be evaluated for safety and entrapment risks by completing a bed assessment. The maintenance staff member reported the facility kept track of mattresses on beds by numbering the mattresses and documenting mattress numbers. The inspector and maintenance staff member confirmed the mattresses in current use by resident #36 and #37 were not numbered. The maintenance staff member confirmed the beds used by resident #36 and #37 were evaluated for entrapment zones by completing a bed assessment. A review of the bed assessments for these beds revealed the mattresses on the beds when the bed assessments were completed were not the same as the mattresses in current use.

The maintenance staff member shared that he was unaware that the mattresses on these two beds had been changed since the time of the bed assessments. He reported the expectation was for staff to inform the maintenance department whenever there was a change to a resident's bed system as the bed system would require a new evaluation for entrapment zones and other risks. The maintenance staff member was unable to confirm that a bed assessment was completed for these bed systems with the mattresses currently on them.

The Assistant Director of Care confirmed that the mattress make and models documented on resident #36 and #37's bed assessment sheets did not match the make and model of mattresses currently on these beds.

The Assistant Director of Care was unable to confirm that resident #36 and #37's current bed systems had been evaluated taking into consideration all potential zones of entrapment and other risks and confirmed the expectation that when there was a change to a resident's bed system and bed rails were used, that bed system must have a new bed assessment completed in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident. [s. 15. (1)(a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used, the resident is assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #3: 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 health record review for resident #31 revealed this resident had experienced altered skin integrity.

The Assistant Director of Care reported weekly skin assessments were required to be documented when the resident experienced altered skin integrity and that this wasn't done for two weeks for resident #31. [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 health record review for resident #33 revealed this resident experienced altered skin integrity. The resident's health record indicated affected skin areas were to be assessed weekly and the assessments were to be documented in th resident's health record. The inspector was unable to locate documented weekly skin assessments for the affected skin areas for four weeks.

The Director of Care reported weekly skin assessments were required to be documented when the resident experienced altered skin integrity and that this wasn't done for four weeks while the resident experienced altered skin integrity. [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 be implemented voluntarily.

WN #4: 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. The licensee failed to ensure that procedures were developed and implemented for 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.

During the initial tour of the home the following was observed:
a. A couch on one home area had areas of staining on it
b. A sliding door on the activity room in one home area had a brown dried substance
c. The couches on one home area were stained and dirty

The sliding door in one home area was cleaned by a housekeeper at the time of observation. One Housekeeper reported the home expected these furnishings to be clean at all times. The Housekeeper confirmed that there was no schedule in place to ensure that furnishings, such as chairs in common areas, were cleaned regularly and that they were cleaned on an as needed basis.

The Environmental Services Supervisor confirmed that there was no regular cleaning schedule for the chairs in the common areas and that the chairs were cleaned on an as needed basis. The Environmental Services Supervisor confirmed that it was the homes expectation that all furnishings were kept clean. [s. 87. (2) (a)]

2. Throughout this Resident Quality Inspection, inspectors observed dark brown laminate floors in resident rooms with multiple white marks. One inspector observed a

housekeeper sweeping the floor in a resident room and the white marks did not come off the floor with sweeping.

One housekeeper reported the white marks on the laminate floors were paint and were removed when the floors were buffed by the housekeeping department. The home had a daily schedule for the buffing of floors in different home areas.

Review of the Floor Cleaning and Buffing records for two home areas revealed floor buffing was not completed as per the home's schedule on the following dates:

- For the month of January 2015 the floors on one home area were not deep cleaned on 10 of 31 days or 32% of the time.
- For the month of February 2015 the floors on one home area were not deep cleaned on 10 of 28 days or 35% of the time.
- For the month of January 2015 the floors on one home area were not deep cleaned on 8 of 31 days or 26% of the time.
- For the month of February 2015 the floors on one home area were not deep cleaned on 9 of 28 days or 32% of the time.

Two Housekeepers reported that the Housekeeping staff regularly worked short staffed and this made them unable to complete their Housekeeping duties. The Housekeepers both confirmed that the floor deep cleaning duties were expected to be completed as per the Housekeeping schedule.

The Administrator verified that there were paint marks on resident room floors and reported the home was considering replacing the floors on the affected units. The Administrator confirmed the expectation was that the home, furnishings and floors were kept clean and sanitary. [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 implemented for 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, to be implemented voluntarily.

WN #5: 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 were labeled properly and were kept inaccessible to residents at all times.

On the initial tour of the home for this Resident Quality Inspection the following was observed:

On one home area the Janitorial room was found unlocked and containing chemicals such as Odour Rite spray, hydrogen peroxide based liquid cleaner, ammonium chloride cleaning solution and two bottles of cleaner with WHMIS labels indicating they were toxic. A Registered Practical Nurse confirmed this door was to be locked as all times and inaccessible to residents.

On one resident area the soiled utility room was found unlocked and contained multiple litres of periwash and an unidentified bottle of fluid with no WHMIS label. A Personal Support Worker confirmed this door was to be locked as all times and inaccessible to residents.

On one home area the activity room cupboard under the sink contained a can of Raid insecticide. A Recreation Aide confirmed this door was to be locked as all times and inaccessible to residents.

The Administrator verified the expectation was that all hazardous substances at the home were labeled properly and were kept inaccessible to residents at all times [s. 91.]

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 all hazardous substances at the home are labeled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rules are complied with: 2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

During the initial tour of the home for this Resident Quality Inspection one inspector observed the door open to the Electrical room on one home area. The room contained an open electrical panel, a heating unit and a pest trap.

A Personal Support Worker and a maintenance staff member confirmed the expectation was that Electrical room doors were locked at all times. [s. 9. (1) 2.]

Issued on this 22nd day of April, 2015

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

Original report signed by the inspector.