Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
January 26, 2011	2011_144_2939_26Jan101740	L-01868 CI -2939-000047-10 L-01879 Infoline IL-15886-LO

LTCH Home Name and Address:
Royal Oak, 1750 Division Road North, Kingsville, ON N9Y 4G7

Licensee Name and Address (If different from above):
Chartwell Master Care LP, 100 Milverton Drive, Suite 700, Mississauga, ON L5R 4H1

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

Carolee Milliner (#144)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident follow-up & info line complaint inspection related to resident to resident abuse.

During the course of the inspection, the inspector spoke with the Administrator, one Director of Care, the Assistant Director of Care, two RPN's & one PSW.

During the course of the inspection, the inspector reviewed the CI report, home Resident Abuse policy & two resident clinical records.

The following Inspection Protocols were used in part or in whole during this inspection:
Responsive Behaviours.

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
2 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O.c,8,s6(1)(c)
Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident.

Findings:
1. Interventions related to the known potential for aggression were not included in the written plan of care for one resident admitted to the home.
2. The written plan of care for one resident does not include interventions related to protecting the resident from recurrence of an assault.

Inspector ID #: 144

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 a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg.79/10,s54(b).
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(2) identifying and implementing interventions.

Findings:
1. The plan of care for one resident does not include the potential for aggression based on an incident identified in the CCAC admission information provided to the home. Resident assaulted another resident of the home.

Inspector ID #: 144

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 steps taken to minimize the risk of altercations and potentially harmful interactions between and among residents including identifying and implementing interventions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O. Reg.79/10,s8(1)(b)
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, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system
(b) is complied with.

Findings:
1. Review of the clinical record for one resident does not provide confirmation that a nursing assessment was completed in response to an assault as required by the homes' Resident Abuse Policy.

Inspector ID #:	144

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** G Millspaugh
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). January 28, 2011