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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
May 24, 2016	2016_257518_0018	002279-16	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

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), CAROLEE MILLINER (144), HELENE DESABRAIS (615)

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): April 25, 26, 27, 28, 29, 2016, May 2, 3, 4, 5, 6, 9, 10, 2016.

During the Resident Quality Inspection the following Critical Incident and Complaint Inspections were completed.
Critical Incidents:
#013791-16 CIS 2939-000022-16 related to resident to resident abuse

#029874-15 CIS 2939-000047-15 related to staff to resident abuse
#029016-15 CIS 2939-000044-15 related to falls prevention
#002323-16 CIS 2939-000005-16 related to staff to resident abuse
#028746-15 CIS 2939-000045-15 related to staff to resident neglect
#027013-15 CIS 2939-000042-15 related to resident to resident abuse with responsive behaviours
#009220-16 CIS 2939-000018-16 related to resident to resident abuse with responsive behaviours
#007087-16 CIS 2939-000016-16 related to resident to resident abuse
#005672-16 CIS 2939-000013-16 related to staff to resident abuse
#012183-16 CIS 2939-000020-16 related to fracture of unknown origin
#004337-16 CIS 2939-000010-16 related to staff to resident abuse/neglect
#001653-16 CIS 2939-000003-16 related to wound care
#029646-15 CIS 2939-000046-15 related to fall with transfer to hospital
#001466-16 CIS 2939-000004-16 related to resident to resident abuse
#035360-15 CIS 2939-000052 reporting of families concerns
Complaints:
#000723-16 IL-42418-LO related to increased number of falls
#001199-15 HLTC2966MC-2015-150 related to a fracture
#027866-15 IL-40972-LO related to resident care
#027558-15 email related to infection control issues
#009781-16 IL-43531-LO related to kitchen and dining area concerns
#008721-14 email related to alleged resident abuse
#001324-16 IL-42419-LO related to residents on waiting lists

During the course of the inspection, the inspector(s) spoke with the Administrator, the Corporate Clinical Educator, the Director of Care(DOC), the Assistant Director of Care(ADOC), the Interim Director of Care(IDOC), The Registered Nurse(RN) Resident Assessment Instrument(RAI) Coordinator, two Registered Nurses(RN), eight Registered Practical Nurses(RPN), sixteen Personal Support Workers(PSW), the Environmental Service Manager(ESM), the Recreation Manager, a Private Care Worker, the Dietary Manager, a Recreation Aide(RecAid), a Restorative Aide(RA), a Physiotherapy Aide(pa), a Cook, three Food Service Workers(FSW), three resident family members and forty residents.

The inspectors also reviewed forty resident clinical records,electronic medication administration records(eMAR), electronic treatment administration records(eTAR) and user defined assessments(UDR), observed recreational and physical therapy,

resident to resident and resident to staff interactions, dining and meal service, medication administration and toured the long term care home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Admission and Discharge
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **4 VPC(s)**
- **3 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. (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 has 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 had an incident that resulted in a change of their medical condition. The resident stated they were unable to reach their medical device which resulted in the incident.

An internal investigation into the circumstances of this incident revealed that a staff member had not placed the medical device within reach of the resident.

Interviews with three staff members confirmed that the medical device should always be left within reach of the resident.

Review of the most recent care plan indicated that the medical device must always be within the resident's reach.

The homes policy LTC-CA-WQ-200-07-1 Resident Safety and Risk Management last revised November 2014, step #7 indicated that care staff are responsible to ensure the medical device is readily available when the residents are in bed or in the washroom.

The DOC verified her expectation was that medical devices be within reach of the resident at all times. [s. 6. (7)]

2. The licensee has 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 had a history of a recurrent medical condition.

The most recent care plan for the resident indicated that they were to be monitored for signs and symptoms of this medical condition.

The resident's plan of care included the Medical Directives and a clinical flow sheet regarding laboratory tests to be completed when a resident exhibits symptoms of the medical condition.

A staff member noted symptoms of the medical condition on three occasions and reported it to the registered nurse however no laboratory tests were completed.

Interviews with three registered staff members confirmed that a laboratory test should have been completed as set out in the plan of care, the medical directives and the clinical flow chart.

The Interim ADOC verified the homes expectation was that care set out in the plan of care should be provided to the resident as set out in the plan. [s. 6. (7)]

3. 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 had a care plan which indicated this resident's sleep and rest routine.

The resident had no history of refusal of care documented in the clinical records.

The resident was found by the afternoon staff not resting in the manner set out in the plan of care.

An interview with the ADOC confirmed that the care was not provided as outlined in this residents care plan. [s. 6. (7)]

4. 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 had a care plan which indicated the dietary restrictions in place.

The resident had a change in their medical condition that required hospitalization.

Review of the twenty four hour shift report note for day shift noted the resident had an increase in dietary intake. The resident required assistance with their dietary needs . It was also written on the report that this resident had specific dietary restrictions.

Review of the resident's care plan revealed that dietary restrictions were in place and that all intake was to be supervised.

An interview with the ADOC confirmed that the care plan had not been followed as dietary restrictions were not followed and the resident was not supervised while consuming dietary items. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that residents were not neglected by the licensee or staff in the home.

A review of a Critical Incident Report revealed that a staff member did not complete a resident's treatment. This treatment was to be completed twice over a specific period of time. The Skin and Wound Coordinator had completed the treatment prior to this and confirmed the treatment had not been completed because the treatment was initialled by the Skin and Wound Coordinator prior to the missed treatments.

A review of the home’s Treatment Administration Record (TAR) for the specified month showed that the treatments were not performed by the staff however the treatments had been checked on the TAR as being refused by the resident and not performed by any other staff.

The resident was not inter viewable and there were no other documented treatment refusals.

Interviews with the two registered staff members confirmed that by reviewing the TAR and reviewing the 24 hour nursing report the treatments were not performed and that no other staff completed the task. They also shared that it was the home’s expectation that registered staff would complete treatments or report the fact that the treatments were not completed on the twenty four hour report or verbally to another registered staff who would complete it on the next shift.

Review of the indicated staff members employee file indicated seven other incidents of care not being completed or care documented as completed when the care had not been provided.

Review of a previous inspection conducted in the home revealed a similar incident where the indicated staff member did not complete a treatment for several days.

Interview with the DOC and Clinical Educator verified that it was the home's expectation that staff would not neglect the residents. [s. 19. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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, was complied with. O. Reg. 79/10, s. 8 (1).

The homes policy LTC-CA-WQ-300-04-02 Food Safety, Sanitation and Infection Control last revised January 2015 indicates that temperatures are to be taken of all foods served to residents, the cook or designate will take the temperatures and record them before delivery to serveries. The Food Service Worker will take and record food temperatures once the food has been placed in the hot table.

Source temperatures taken in the kitchen prior to delivery to the serveries were not documented on:
April 9 , 2016 at the breakfast and lunch meal
April 10, 2015 at the breakfast and lunch meal
April 24, 2016 at the breakfast and lunch meal
April 23, 2016 at the dinner meal
April 24, 2016 at the dinner meal
March 10, 2016 at the dinner meal
March 11, 2016 at the dinner meal
March 14, 2016 at the breakfast and lunch meal

March 15, 2016 at the breakfast and lunch meal
March 18, 2016 at all meals
March 20, 2016 at the breakfast and lunch meal

The Dietary Manager, Cook and FSW confirmed these temperatures were not documented.

The homes policy LTC-CA-WQ-300-04-07 Food Safety, Sanitation and Infection Control last revised January 2015, indicates that refrigerator and freezer temperatures are to be taken and documented in the morning and the evening and dish washer temperatures must be taken and documented after each meal service.

Oak
There are no documented refrigerator temperatures, freezer temperatures, dishwasher wash or rinse cycle temperatures completed on April 1, 2016 in the morning, April 2, 3, 4, 5 all day and April 20, 2016, in the morning.

Copper Beach
There are no documented refrigerator temperatures, freezer temperatures, dishwasher wash or rinse cycle temperatures completed on April 1, 2, 3, 4, 5, 6, 19, 24, 25, 29 and 30, 2016.

Blue Spruce
There are no documented refrigerator temperatures, freezer temperatures, dishwasher wash or rinse cycle temperatures completed on April 1, 2, 3 in the evening, 4 in the evening, 5 in the evening,12 in the morning, 16, 2016.

The Dietary Manager, Cook and FSW confirmed these temperatures had not been documented.

The homes policy LTC-CA-WQ-300-04-08 Food Safety, Sanitation and Infection Control last revised January 2015, indicated that there was a cleaning schedule that included jobs and routines and it encompassed all shifts.
The employee will complete the jobs and initial the cleaning schedule when completed.
The Equipment Pre-Inspection Checklist will be completed and signed with any abnormalities reported to the Manager

Oak

Pre-Start up Inspection Checklist documentation was not completed April 1, 2, 3, 4, 5, 18 and 19, 2016.
Daily Servery Cleaning Checklist documentation for the day shift was not completed April 1, 2, 3, 4, 5, 8, 18 and 19, 2016.
Daily Servery Cleaning Checklist documentation for the evening shift was not completed April 1, 2, 3, 4, 5, 8, 18 and 19, 2016.

Copper Beach
Pre-Start up Inspection Checklist documentation was not completed April 1, 2, 3, 4, 5, 6, 7, 11, 12, 17, 20, 24, 25, 26, 28, 2016.
Daily Servery Cleaning Checklist documentation for the day shift was not completed April 1, 2, 3, 4, 5, 6, 7, 11, 12, 14, 17, 20, 21, 24, 25, 26, 2016.
Daily Servery Cleaning Checklist documentation for the evening shift was not completed April 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 21, 23, 24, 25, 27, 28, 29, 30, 2016.

Blue Spruce
Pre-Start up Inspection Checklist documentation was not completed on April 1, 2, 8, 10, 12, 16, 22, 2016.
Daily Servery Cleaning Checklist documentation for the day shift was not completed April 1, 2, 8, 12, 16, 2016.
Daily Servery Cleaning Checklist documentation for the evening shift was not completed April 1, 2, 3, 4, 6, 8, 10, 13, 16, 18, 19, 22, 24, 27, 28, 29, 30, 2016.

The Dietary Manager, Cook and FSW confirmed these start ups and cleaning practices had not been signed for.

The DOC verified that the homes expectation was that all policies be complied with. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident.

Review of two incident reports dated the same day indicated that two residents did not receive a medication on one medication pass which resulted in contact with a physician and increased monitoring of these two residents.

Interviews with DOC, Corporate Educator, and the Administrator revealed that they did not agree that the incidents of omission of medication should have been reported to the Ministry of Health and Long Term Care because the residents were not transported to the hospital under the section 107 of the Regulations.

The Administrator shared that after review of the medication incident report she agreed that a resident with abnormal laboratory tests was at risk of harm and any incident that results in harm or a risk of harm to a resident should have been reported and she would share that education with the staff. [s. 24. (1) 1.]

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 any person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and that minimize the risk of altercations and potentially harmful interactions between and among residents.

An incident of a responsive behaviour occurred between two residents . There were no ill effects from the incident to either resident.

As a result of the incident one resident required increased monitoring to ensure the residents whereabouts and activities on the unit.

Review of the "Monitoring Record" for this resident indicated:
Incomplete documentation for the day and evening shift on four dates.
No documentation on two dates.

An interview with ADOC confirmed that the resident was to be monitored at specified intervals and observations should have been documented. She confirmed that the documentation was incomplete on the records and it was expected that staff complete the documentation at specified intervals. [s. 55. (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 and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids were stored using methods which preserve taste, nutritive value, appearance and food quality.

The homes policy LTC-CA-WQ-300-04-04 Food Safety, Sanitation and Infection Control last revised January 2015 indicated that food must be stored in a suitable sterile container with a lid or a sterile plastic bag, it was to be labelled with a date, meal time, and food type. These foods will be placed in a designated area in the fridge. The cook will discard the outdated food after seven days.

Observations completed on two dates revealed:
Main Kitchen
First Freezer Left Shelf
These Items were sealed in tupperware
-Pureed gluten free something dated 2/12
-gluten free pork chops dated 5/4
-pureed pork dated 3/2
-minced chicken dated 2/12
-beef steak dated 3/2
-expired yogurt dated December 29, 2015
-a plastic bag of pepperoni undated and unlabelled
-a plastic bag of beef burgers undated and unlabelled

Copper Beach Servery Fridge
-unsealed cottage cheese and poppy seed dressing containers
-uncovered undated Tupperware container with 4 ½ egg salad sandwiches in the fridge
-uncovered undated orange juice container
-one jug of opened uncapped thickened hydration fluid
-thickened milk hydrating beverage found opened in the fridge
-Cesar dressing dated 4/4
-multiple containers of thickened ice cream in a secondary container unlabelled and undated

These observations were confirmed by a Cook, three PSW's, one FSW , and one RA .

The Dietary Manager verified that the expectation was that all fluids and food was stored using methods which preserve taste, nutritive value, appearance and quality. [s. 72. (3) (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 all foods and fluids prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #7: 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).

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

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

An anonymous complaint was received by the Ministry of Health and Long Term Care which alleged the mechanical lifts were unclean.

Observations made on two different dates on the same units observing the same lifts revealed:

Mulberry Unit
The Maxi Lift had dried food particles yellow to brown in colour, yellow and brown staining on the base of the support bars.
A sitting chair in hallway with brown staining on the seat cushion was visible.
This was confirmed by a staff member.

Blue Spruce
The Sara Lift had dried food debris on foot peddle base and dried brown debris on the base support and a resident room had the call bell laying on floor.
This was confirmed by a staff member.

Oak
Oak Common Room
An unplugged fridge with a foul odour coming from it was noted, inside was a used tissue, a half eaten uncovered unlabelled sandwich and a glass with one inch of curdled chocolate milk with a film on it. This room is a common activity room for residents with dementia within a secured unit. There were seven residents in the room at the time of the observation.
This was confirmed by two staff members.

Review of May Lift Inspection and Cleaning Logs revealed that on twelve shifts over eight days there was no documentation of cleaning of these lifts.

The homes policy LTC-CA-WQ-205-02-01 Infection Prevention Cleaning, Disinfecting and Sterilizing indicates that if a lift or transfer device is soiled it is to be taken to a utility room and cleaned and all lifts are to cleaned and inspected on midnight shift.

Three registered staff members confirmed it was the expectation that all lifts are cleaned and documented on the Lift Inspection Checklist.

The Administrator verified the lifts must be cleaned daily as part of the infection and control program. [s. 229. (4)]

2. The licensee has failed to ensure that staff on every shift record symptoms of infection in residents and take immediate action as required.

Review of a resident's progress notes revealed that a resident demonstrated symptoms of a medical illness which required treatment over a one month period, then developed the same symptoms again over a separate time period again requiring treatment.

Review of the Daily Surveillance Tracking Form for the resident's unit for the two month period revealed that symptoms were only documented on one day and that the treatments were not documented on an infection report.

Review of the home's policy titled "Daily Infection Surveillance", policy number LTC-CA-WQ-205-03-02, last revised in March 2016, revealed the steps staff are to follow in the procedure section to manage infections in the home:
Step 4: When any of the above symptoms are identified, the Registered Staff is to record the resident name and room number on the Daily Infection Surveillance Form using the legend on the form.
Step 5: The Registered Staff will then complete the Infection Report User Defined Assessment (UDA) in Point Click Care (PCC) to document in the resident's record the symptoms, laboratory tests and results as applicable, precautions and any further follow-up actions required. The Infection Report once locked in PCC will auto-populate a Progress Note. Ongoing documentation during the course of the infection related to the resident status and actions taken is to be completed in the progress notes.
Step 6: Based on symptoms displayed Registered Staff will implement any required precautions or control measures in keeping with policies and procedures in the Infection Control Manual.
Step 7: Registered Staff are to indicate on the Daily Report sheet the name of the resident and the symptoms the resident is displaying.
Step 9: Subsequent shifts are to continue assessing and observing residents with symptoms recording findings using the legend on the Daily Infection Surveillance Form.

An interview with ADOC confirmed the home's expectation that resident symptoms of infection are documented on the Daily Infection Surveillance by the Registered Staff and that the Registered Staff are required to complete an Infection Report with the initiation of antibiotic therapy. She confirmed that the resident should have had precautions initiated. She confirmed that the home's staff did not complete the required above mentioned documentation and therefore are not participating in the daily monitoring of infections in residents. [s. 229. (5) (b)]

3. The licensee has failed to ensure that staff record symptoms of infection in residents and take immediate action as required.

A resident had five episodes of symptoms of a medical illness over a six month period.

The home's policy Infection Control Daily Infection Surveillance LTC-CA-WQ-205-0302 indicated that these medical symptoms were to be documented on the Daily Surveillance Tracking Form.

Interviews with three registered staff members confirmed this resident had symptoms of a medical illness on five occasions over the six month period and the symptoms should have been documented on the Daily Surveillance Form by a registered staff member on a per shift basis until they resolve or an antibiotic has been started.

The DOC and Clinical Educator verified that the homes expectation was that all staff record signs and symptoms of infection on the Daily Surveillance Tracking Form set out in the Infection Control Program. [s. 229. (5) (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 all staff participate in the implementation of the program and on every shift the symptoms are recorded and that immediate action is taken as requires, to be implemented voluntarily.

Issued on this 19th day of July, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ALISON FALKINGHAM (518), ALICIA MARLATT (590), CAROLEE MILLINER (144), HELENE DESABRAIS (615)
Inspection No. / No de l'inspection :	2016_257518_0018
Log No. / Registre no:	002279-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 24, 2016
Licensee / Titulaire de permis :	Chartwell Master Care LP 100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1
LTC Home / Foyer de SLD :	THE ROYAL OAK LONG TERM CARE CENTRE 1750 Division Road North, KINGSVILLE, ON, N9Y-4G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JAYNE BROOKS KELLER

To Chartwell Master Care LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must ensure:
a) a resident has the use of a mechanical device within reach at all times
b) a resident has appropriate laboratory tests taken when presenting with symptoms of a medical condition
c) a resident's sleep and rest routines are followed
d) a resident's dietary restrictions are followed

Grounds / Motifs :

1. 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 had a care plan which indicated the dietary restrictions in place.

The resident had a change in their medical condition that required hospitalization.

Review of the twenty four hour shift report note for day shift noted the resident had an increase in dietary intake. The resident required assistance with their dietary needs . It was also written on the report that this resident had specific dietary restrictions .

Review of the resident's care plan revealed that dietary restrictions were in place and that all intake is to be supervised.

An interview with the ADOC confirmed that the care plan had not been followed as dietary restrictions were not followed and the resident was not supervised while consuming dietary items. [s. 6. (7)]

(590)

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 had a care plan which indicated this resident's sleep and rest routine.

The resident had no history of refusal of care documented in the clinical records.

The resident was found by the afternoon staff not resting in the manner set out in the plan of care.

An interview with the ADOC confirmed that the care was not provided as outlined in this residents care plan. [s. 6. (7)]

(590)

3. The licensee has 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 had a history of a recurrent medical condition.

The most recent care plan for the resident indicated that they were to be monitored for signs and symptoms of this medical condition.

The resident's plan of care included the Medical Directives and a clinical flow sheet regarding laboratory tests to be completed when a resident exhibits symptoms of the medical condition.

A staff member noted symptoms of the medical condition on three occasions and reported it to the registered nurse however no laboratory tests were completed.

Interviews with three registered staff members confirmed that a laboratory test should have been completed as set out in the plan of care, the medical directives and the clinical flow chart.

The Interim ADOC verified the homes expectation was that care set out in the

plan of care should be provided to the resident as set out in the plan. [s. 6. (7)]

(518)

4. The licensee has 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 had an incident that resulted in a change of their medical condition. The resident stated they were unable to reach their medical device which resulted in the incident.

An internal investigation into the circumstances of this incident revealed that a staff member had not placed the medical device within reach of the resident.

Interviews with three staff members confirmed that the medical device should always be left within reach of the resident.

Review of the most recent care plan indicated that the medical device must always be within the resident's reach.

The homes policy LTC-CA-WQ-200-07-1 Resident Safety and Risk Management last revised November 2014, step #7 indicated that care staff are responsible to ensure the medical device is readily available when the residents are in bed or in the washroom.

The DOC verified her expectation was that medical devices be within reach of the resident at all times. [s. 6. (7)]

The scope of this issue was isolated. The severity of the issue was determined to be a level three with actual risk or harm to residents. The home did have a history of non-compliance with this subsection of the regulation . It was issued as a WN and VPC January 9, 2016 resulting from a complaint inspection 2015_257518_0069, a WN and VPC May 28, 2015 resulting from a critical incident inspection 2015_349590_0019, and a WN on May 14, 2014 resulting from the resident quality inspection 2014_257518_0022..

(518)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 15, 2016

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall ensure that registered staff members do not neglect resident's care.
The licensee will implement an audit plan to ensure that registered staff members complete any resident treatments as per the plan of care and any assessments as necessary.
The licensee will include in the plan any necessary protocols for reporting to the governing body for the failure of the registered staff members to provide the care required by this resident or any other resident.

Grounds / Motifs :

1. The licensee had failed to ensure that residents were not neglected by the licensee or staff in the home.

A review of a Critical Incident Report revealed that a staff member did not complete a resident's treatment. This treatment was to be completed twice over a specific period of time. The Skin and Wound Coordinator had completed the treatment prior to this and confirmed the treatment had not been completed because the treatment was initialled by the Skin and Wound Coordinator prior to the missed treatments.

A review of the home's Treatment Administration Record (TAR) for the specified month showed that the treatments were not performed by the staff however the treatments had been checked on the TAR as being refused by the resident and not performed by any other staff.

The resident was not interviewable and there were no other documented treatment refusals.

Interviews with the two registered staff members confirmed that by reviewing the TAR and reviewing the 24 hour nursing report the treatments were not performed and that no other staff completed the task. They also shared that it was the home's expectation that registered staff would complete treatments or report the fact that the treatments were not completed on the twenty four hour report or verbally to another registered staff who would complete it on the next shift.

Review of the indicated staff members employee file indicated seven other incidents of care not being completed or care documented as completed when the care had not been provided.

Review of a previous inspection conducted in the home revealed a similar incident where the indicated staff member did not complete a treatment for several days.

Interview with the DOC and Clinical Educator verified that it was the home's expectation that staff would not neglect the residents. [s. 19. (1)]

The scope of this issue is isolated. The severity of this issue was determined to be a level three with actual risk or harm to residents. The home did have a history of non-compliance with this sub-section of the regulation. A compliance order was issued October 23, 2015, which resulted from a critical incident 2015_276537_0043 which was complied December 22, 2015 . (615)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 15, 2016

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must ensure:
a) that source temperatures are taken and documented in the kitchen prior to delivery of food to the serveries
b) that refrigerator temperatures are taken twice daily and dishwasher temperatures are taken after each meal service
c) that the Pre-Start up Inspection Checklists are completed and documented daily and the Daily Servery Cleaning Checklists are completed and documented on the day and evening shift.

Grounds / Motifs :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system, was complied with. O. Reg. 79/10, s. 8 (1).

The homes policy LTC-CA-WQ-300-04-02 Food Safety, Sanitation and Infection Control last revised January 2015 indicates that temperatures are to be taken of all foods served to residents, the cook or designate will take the temperatures and record them before delivery to serveries. The Food Service Worker will take and record food temperatures once the food has been placed in the hot table.

Source temperatures taken in the kitchen prior to delivery to the serveries were not documented on:
April 9 , 2016 at the breakfast and lunch meal
April 10, 2015 at the breakfast and lunch meal

April 24, 2016 at the breakfast and lunch meal
April 23, 2016 at the dinner meal
April 24, 2016 at the dinner meal
March 10, 2016 at the dinner meal
March 11, 2016 at the dinner meal
March 14, 2016 at the breakfast and lunch meal
March 15, 2016 at the breakfast and lunch meal
March 18, 2016 at all meals
March 20, 2016 at the breakfast and lunch meal

The Dietary Manager #128, Cook#132 and FSW#131 confirmed these temperatures were not documented.

The homes policy LTC-CA-WQ-300-04-07 Food Safety, Sanitation and Infection Control last revised January 2015, indicates that refrigerator and freezer temperatures are to be taken and documented in the morning and the evening and dish washer temperatures must be taken and documented after each meal service.

Oak
There are no documented refrigerator temperatures, freezer temperatures, dishwasher wash or rinse cycle temperatures completed on April 1, 2016 in the morning, April 2, 3, 4, 5 all day and April 20, 2016, in the morning.

Copper Beach
There are no documented refrigerator temperatures, freezer temperatures, dishwasher wash or rinse cycle temperatures completed on April 1, 2, 3, 4, 5, 6, 19, 24, 25, 29 and 30, 2016.

Blue Spruce
There are no documented refrigerator temperatures, freezer temperatures, dishwasher wash or rinse cycle temperatures completed on April 1, 2, 3 in the evening, 4 in the evening, 5 in the evening,12 in the morning, 16, 2016.

The Dietary Manager #128, Cook#132 and FSW#131 confirmed these temperatures had not been documented.

The homes policy LTC-CA-WQ-300-04-08 Food Safety, Sanitation and Infection Control last revised January 2015, indicated that there was a cleaning schedule

that included jobs and routines and it encompassed all shifts.
The employee will complete the jobs and initial the cleaning schedule when completed. The Equipment Pre-Inspection Checklist will be completed and signed with any abnormalities reported to the Manager

Oak
Pre-Start up Inspection Checklist documentation was not completed April 1, 2, 3, 4, 5, 18 and 19, 2016.
Daily Servery Cleaning Checklist documentation for the day shift was not completed April 1, 2, 3, 4, 5, 8, 18 and 19, 2016.
Daily Servery Cleaning Checklist documentation for the evening shift was not completed April 1, 2, 3, 4, 5, 8, 18 and 19, 2016.

Copper Beach
Pre-Start up Inspection Checklist documentation was not completed April 1, 2, 3, 4, 5, 6, 7, 11, 12, 17, 20, 24, 25, 26, 28, 2016.
Daily Servery Cleaning Checklist documentation for the day shift was not completed April 1, 2, 3, 4, 5, 6, 7, 11, 12, 14, 17, 20, 21, 24, 25, 26, 2016.
Daily Servery Cleaning Checklist documentation for the evening shift was not completed April 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 21, 23, 24, 25, 27, 28, 29, 30, 2016.

Blue Spruce
Pre-Start up Inspection Checklist documentation was not completed on April 1, 2, 8, 10, 12, 16, 22, 2016.
Daily Servery Cleaning Checklist documentation for the day shift was not completed April 1, 2, 8, 12, 16, 2016.
Daily Servery Cleaning Checklist documentation for the evening shift was not completed April 1, 2, 3, 4, 6, 8, 10, 13, 16, 18, 19, 22, 24, 27, 28, 29, 30, 2016.

The Dietary Manager #128, Cook #132 and FSW #131 confirmed these start ups and cleaning practices had not been signed for.

The DOC #102 verified that the homes expectation was that all policies be complied with.

The scope of this issue was widespread. The severity of the issue was determined to be level two with potential for risk or harm to residents. The home did have a history of non-compliance with this sub-section of the regulation. It

was issued as a WN on May 14, 2014, during the resident quality inspection 2014_257518_0022 and as a WN and VPC on August 6, 2013 resulting from a critical incident 2013_217137_0014. (518)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 15, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 24th day of May, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Alison Falkingham

Service Area Office /
Bureau régional de services : London Service Area Office