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

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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
Jul 10, 13, 2017	2017_531518_0016	003261-17	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

Chartwell Royal Oak Long Term Care Residence
1750 Division Road North KINGSVILLE ON N9Y 4G7

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

ALISON FALKINGHAM (518), ANDREA DIMENNA (669), 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 24, 25, 26, 27, 28, 2017 May 1, 2, 3, 4, 2017

Also completed within this Resident Quality Inspection:
Log #029066-16 CIS 2939-000055-16 related to resident elopement
Log #033179-16 CIS 2939-000063-16 related to a fracture
Log #025989-16 CIS 2939-000045-16 related to alleged abuse
Log #027463-16 CIS 2939-000050-16 related to a fall

Log #033488-16 CIS 2939-000064-16 related to a fall
Log #029818-16 CIS 2939-000058-16 related to alleged abuse
Log #026141-16 CIS 2939-000046-16 related to resident elopement
Log #023723-16 CIS 2939-000041-16 related to alleged abuse
Log #027679-16 CIS 2939-000051-16 related to wound care
Log #020787-16 CIS 2939-000036-16 related to alleged abuse
Log #019666-16 CIS 2939-000033-16 related to continence care
Log #027019-16 CIS 2939-000047-16 related to a fall
Log #031461-16 CIS 2939-000059-16 related to alleged abuse
Log #019427-16 CIS 2939-000029-16 related to alleged abuse
Log #031330-16 SAC 13757 related to alleged abuse
Log #027096-16 CIS 2939-000048-16 related to falls
Log #024530-16 CIS 2939-000043-16 related to alleged abuse
Log #002316-16 CIS 2939-000003-17 related to alleged neglect

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care(DOC), three Assistant Directors of Care(ADOC), six Registered Nurses(RN), 11 Registered Practical Nurses(RPN), 12 Personal Support Workers (PSW), one Housekeeper(HSK), one Environmental Service Manager, 49 residents, three resident family members and a Resident's Council representative.

The Inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed meal and snack service,
medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC - Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO - Work and Activity Order	Legendé WN – Avis écrit VPC - Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO - Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non- respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system calls can be cancelled only at the point of activation.

A resident's Power of Attorney (POA) sent an email of complaint to the DOC related to concerns about the wait time being to long to receive assistance when the call bell was activated. They had also noticed that the red light on the wall plate of the call bell came on when they activated the call bell system and then noticed the red light would go off. The complainant noted that this happened more than one time that day.

The home's policy Resident Safety and Risk Management Resident Safety-Door Alarms, Nurse Call System and Rounds LTC-CA-WQ-200-07-10 last revised November 2014 stated:
The home will maintain and operate a nurse call system that is compliant with jurisdictional regulations. Under no circumstances is a resident to be discouraged from using the nurse call system nor is a resident to be refused the call bell.

Interview with the Environmental Services Manager stated that they were aware of the family's concerns. Interventions were put in place and tried.

The Environmental Services Manager had been concerned that the sensitivity of the call bells that had been tried made it easier to turn off the call bells in the resident's room by moving it or laying clothing on it.

The inspector observed two other residents in their rooms, both resident's rooms were equipped to use the soft touch call bells. The inspector activated both of these call bells and then attempted to turn them off by lightly touching them or laying a sheet on them in order to see if the call bells could be turned off accidentally at the bedside. Neither of the soft touch call bells turned off when touched lightly.

An interview with a staff member stated that call bell audits occur on an ongoing basis and the audit reports are kept in the Environmental Services Office.

The inspector made observations of twenty call bells which showed that all twenty call bells lit up and sounded when activated and they could be turned off at the point of activation.

Interviews with three staff members stated that all call bells in the home can be turned off at the nursing desk by picking up the telephone receiver and then placing it back in its cradle. This was demonstrated to the inspector by staff members who activated a resident's call bell within the room and then hanging up the phone at the nursing desk, the red activation light went out on the call bell wall plate and the alarm at the nursing desk ceased.

The Administrator stated the resident-staff communication and response system should only be cancelled at the point of activation, never by using the telephone cradle at the nursing desk. The wiring for a new resident-staff call bell system was put in place in the summer of 2016 however the new resident-staff call bell system on order had some system issues that needed to be corrected before installation could be completed. The Administrator could not tell the Inspector when the rest of the new resident-staff call bell system would be installed.

The licensee failed to ensure that the resident-staff communication and response system can be cancelled only at the point of activation.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection.

The home does not have a history of non compliance in this subsection of the legislation. [s. 17. (1) (c)]

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 the home is equipped with a resident-staff communication and response system that allows calls to be cancelled only at the point of activation, to be implemented voluntarily.

WN #2: 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. O. Reg. 79/10, s. 30 (2).

A resident was admitted to the home with multiple diagnoses.

The resident was interviewed by an inspector and reported that while being transferred by staff members an incident occurred that resulted in an injury.

The resident’s Power of Attorney (POA), reported that resident called them on the telephone and reported the incident which occurred the night before. The Power of Attorney said that the resident shared they had received an injury as a result of this incident. The Power of Attorney acknowledged that they visited the resident several days later and observed an injury.

Two staff were interviewed and acknowledged they were the staff members who transferred the resident when the incident occurred.
Two staff members explained that this occurred when the resident had many behaviours. One staff member said that they did not document the incident. Two staff members both reported that they called a registered staff member, who came and spoke to the resident.

The resident's chart was reviewed, and did not include any documentation of the incident, assessment of the resident, or specific flow sheet related to the incident described by resident and acknowledged by the two staff members.

A review of the home's policy, "Head Injury #RET-CA-ALL-215_04_09," dated December 10, 2015, stated that all residents who may have sustained an injury to their head as a result of a fall or other such incident where the resident's head may have come in contact with a hard surface and sustained an injury will be assessed by a registered staff. The policy included a note that not all head injuries are an observable injury, and that registered staff should initiate a head injury assessment and routine. The policy also said that all staff who witnessed or became aware of a resident fall, blow or injury where the resident head has made contact with a floor or other object must report the known injury or the information provided to them regarding an injury to registered staff for an assessment. The policy included that registered staff should complete all documentation including: progress notes, an incident report, the physician communication book, 24-hour report/communication log, and updating the resident's care plan.

Two staff members were interviewed and stated that if any resident was witnessed hitting their head, they would start a head injury routine, assess the resident, and enter the incident into risk management. Two registered staff members explained that they would follow this process even if the resident had no visible injury and if the resident stated they were okay.
A staff member explained that if a resident was witnessed hitting their head, they would do vitals, a neurological assessment, follow head injury routine, and document the incident

in the 24-hour report as well as in risk management. The registered staff member was unable to recall the specific incident involving the resident, and stated they did not document this incident. The staff member reported that it was very likely that staff called them after this incident, and that if the resident had no obvious injuries, the RN may not have documented the incident or further assessed the resident. A registered staff member acknowledged that this incident should have been documented.

An interview with the Director of Care acknowledged that this incident should have been documented by the RN or RPN in the progress note and an appropriate flow sheet should have been implemented as stated by the home's policy.

The licensee failed to ensure that any actions taken with respect to a resident hitting their head, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on February 25, 2015 as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection 2015_256517_0006. [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 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, to be implemented voluntarily.

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Issued on this 13th day of July, 2017

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

Original report signed by the inspector.