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 # / No de registre	Type of Inspection / Genre d'inspection
Dec 20, 2017	2017_538144_0052	027547-17	Critical Incident System

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

CAROLEE MILLINER (144)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 5, 6, 7, 2017.

Critical Incident 2939-000046-17 was inspected related to an unexpected event.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, two Registered Nurses, three Registered Practical Nurses and five Personal Support Workers.

During the course of the inspection, the inspector reviewed one resident clinical record, the home's Personal Support Workers Job Routine and relevant policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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. 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 instituted or otherwise put in place was complied with.

Ontario Regulation 79/10, s.30(1) states, "Every licensee shall ensure that the following is complied with in respect of each organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required."

The Long-Term Care Home's Act, 2007 S.O. 2007, c. 8, 8(1)(b) states, "Every licensee of a long-term care home shall ensure that there is an organized program of personal support services for the home to meet the assessed needs of the resident."

Critical Incident System Report #2939-000046-17 was submitted to the Ministry of Health and Long-Term Care on November 30, 2017, related to an unexpected event.

Review of the home’s Personal Support Worker (PSW) Job Routine for the midnight shift included the directive that each PSW was responsible to ensure they documented care they provided throughout the shift in Point of Care (POC).

One resident was found by a PSW having experienced an unexpected event on an identified date.

One PSW advised the inspector that they provided care to the resident with assistance from a second PSW during the first set of rounds on a specific night shift. The PSW further stated that they also provided care to the same resident at four different intervals on the same night shift without assistance from other nursing personnel.

The second PSW agreed that they assisted the first PSW to provide care twice to the resident on the same night shift and that they did not assist the PSW again to provide care to the resident throughout the remainder of the shift.

Review of the resident's clinical record stated that care was provided to the resident by the first PSW once and by the second PSW twice during the identified midnight shift.

The first PSW said that they did not document the care they provided twice to the resident in POC on the identified night shift as it was the responsibility of the float staff on the night shift to complete the documentation for care that was provided to residents on this particular resident home area.

The second PSW shared that they were the float PSW for the night shift and that they completed the documentation in POC for the care provided to the resident during that shift. The PSW said that the first PSW had shared with them the care that they had provided to the resident during the night shift and that they documented in POC accordingly.

The second PSW also said that during orientation to the resident home area, they were taught that the float PSW completed the documentation in POC for the care provided to the residents on that unit.

The Administrator acknowledged during a telephone interview with the inspector that they were aware that the second PSW had documented in POC that they provided care to the resident when in fact the first PSW had provided the care.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of the issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home as a Compliance Order (CO) with the Resident Quality Inspection (RQI), 2016_257518_0018 on April 25, 2016. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

Issued on this 21st day of December, 2017

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

Original report signed by the inspector.