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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 13, 2018	2018_563670_0018	017175-18	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

DEBRA CHURCHER (670), HELENE DESABRAIS (615), INA REYNOLDS (524), NANCY SINCLAIR (537)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): August 13, 14, 15, 16, 17, 20, 21, 22, 23 and 24, 2018.

The following complaints were inspected during this Resident Quality Inspection (RQI):
Log #009215-17 Related to a written complaint submitted to the home related to alleged improper care.
Log #010800-18 Infoline #57081-LO related to alleged medication error.

Log #008854-17 Infoline #50639-LO related to alleged failure to provide pain control, monitor weight,and menu planning.
Log #009031-18 Infoline #56769-LO related to alleged resident to resident abuse.
Log #019199-18 Infoline #58400-LO related to alleged improper care.
Log #023737-17 CIS#2939-000041-17 related to a medication error.
Log #009085-17 CIS#2939-000012-17 related to alleged staff to resident abuse.
Log #023915-17 CIS#2939-000040-17 related to alleged staff to resident abuse.
Log #011090-17 CIS#2939-000022-17 related to alleged staff to resident abuse.
Log #018347-18 CIS#2939-000013-18 related to alleged staff to resident abuse.
Log #011252-17 CIS#2939-000024-17 related to alleged resident to resident abuse.
Log #024717-17 CIS#2939-000043-17 related to alleged resident to resident abuse.
Log #029392-17 CIS#2939-000049-17 related to alleged resident to resident abuse.
Log #027697-17 CIS#2939-000045-17 related to alleged resident to resident abuse.
Log #009158-18 CIS#2939-000011-18 related to alleged resident to resident abuse.
Log #009754-17 CIS#2939-000013-17 related to a fall with injury.
Log #028707-17 CIS#2939-000048-17 related to a fall with injury.

During the course of the inspection, the inspector(s) spoke with more than twenty residents, 4 Family members, Residents' Council representative, the Administrator, the Director of Care, the Assistant Director of Care, the Social Worker, the Recreation Manager, the Resident Assessment Instrument Coordinator, 2 Registered Nurses, twelve Registered Practical Nurses, fourteen Personal Support Workers, and 1 Recreation Aide.

During the course of the inspection, the inspectors toured all resident home areas, observed the general maintenance and cleanliness of the home, medication administration, the provision of resident care, recreational activities, staff to resident interactions, infection prevention and control practices, reviewed resident clinical records, observed the posting of required information and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

On a specific date CI #2939-000013-18/Log #018347-18 related to alleged neglect of resident #013 was submitted to the Ministry of Health and Long Term Care (MOHLTC).

On a specific date Complaint IL-58400-LO/Log #019199-18 related to alleged improper care of resident #013 was submitted to the MOHLTC.

During a telephone interview, on a specific date, the complainant who was also the Power of Attorney (POA) for resident #013 spoke with Inspector #537 and shared their concerns related to the lack of care of the resident during a specific time frame. The complainant stated that they would forward an email of their concerns.

A review of the complainant's email sent on a specific date, to the MOHLTC, outlined the POA's specific concerns regarding specific care and assessments that were not completed. Resident #013 passed away on a specific date at a specific location.

A review of resident #013's progress notes in PCC indicated that on a specific date, two registered staff did notice a change in resident #013's condition.

A review of resident #013's progress notes in PCC indicated in part that on a specific date, resident #013 was exhibiting specific symptoms, including specific vital signs that were out of the normal range and that the family had expressed concerns.

A review of resident #013's progress notes in PCC indicated in part that on a specific date, the resident was exhibiting specific symptoms, including specific vital signs that were it if the normal range and that a discussion had occurred with a family member.

A review of resident #013's progress notes in PCC indicated in part on a specific date that the Death Certificate had been received with a primary and secondary cause of death listed.

A review of the home's investigation documents revealed the following:

-Change in condition first noted on a specific date;

-Resident sent to hospital on a specific date;
-Resident expected to maybe return to the home on a specific date - specific care status identified;
-A low specific vital sign is as indicative of an infectious process as a high specific vital sign in the elderly;
-May have considered other infectious processes. Did we consider calling the physician? When change noted on specific dates.

A review of the home's investigation documents included staff interviews as follow:

Staff interviews started on a specific date: Administrator #111 and Assistant Director of Care #101 met with resident #013's POA where care concerns were expressed about the resident's care during a specific time frame.

On different dates, eight staff, RN #123, RPNs #124, #125 and #126, PSWs #127, #128, #128, #129 and #130, reported they had observed a health decline in the resident starting on a specific date.

There were no documented evidence that the registered staff contacted the physician or assessments were completed to determine the needs of the resident when there was a change in their health conditions.

During an interview on August 21, 2018, ADOC #101, stated that resident #013's health was declining during a specific time frame and that the physician should have been contacted so that the resident could be assessed and interventions be in place.

During an interview, Administrator #111 and DOC #100 agreed that resident #013’s health was declining since a specific date and that the physician should have been notified so that the resident would be assessed and care needs identified for interventions.

The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed. [s. 6. (10)]

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 ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (a) a goal in the plan is met; (b) the resident's care needs change or care set out in the plan is no longer necessary; or (c) care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, the behavioural triggers for the resident were identified, strategies were developed and implemented to respond to those behaviours, and actions were taken to respond to the needs of the resident, including reassessments.

Resident #012 was admitted to the home on a specific date, with a specific diagnosis.

The home's policy titled "Responsive Behaviour – Aggressive or Violent Episode, LTC-CA-WQ-200-07-14", last revised December 2017, stated in part: Following completion of the MDS assessment, Registered Staff will review the outcome scores of the MDS. If the

ABS is 2 or greater a care plan will be developed to address the risk of aggressive or violent behaviour. Quarterly, the MDS, the Aggressive Behaviour Scale (ABS) and the care plan will be reviewed and updated with further information that is known about the resident."

Scoring for the ABS was as follows:
0 No risk of aggressive behaviour
1-2 Moderate risk of aggressive behaviour
3-5 Severe risk of aggressive behaviour
6+ Very severe risk

The policy also stated: "Following a new or changed aggressive outburst, staff involved in the situation will have a Responsive Behaviour de-brief to look for triggers to the behaviour, what interventions worked, what did not work and then update the care plan accordingly."

On admission, the ABS score of the MDS assessment for resident #012 dated for a specific date, was noted to be two (2), moderate risk of aggressive behaviour.

The ABS score of the most recent MDS assessment dated for a specific date, was noted to be three (3), severe risk of aggressive behaviour.

A Critical Incident System (CIS) report 2939-000045-17 was submitted to the Ministry of Health and Long Term Care (MOHLTC) on a specific date. The report stated that resident #014 was in the bedroom of resident #012, on the floor and this was unwitnessed by staff. Resident #012 was observed by staff exiting their room and closing the door, just prior to resident #014 being found on the floor. Resident #014 suffered a specific injury. The home completed an internal investigation, including interview of both residents, with inconclusive evidence to support what had actually occurred, but submitted a CIS due to the known history of behaviours of resident #012.

A CIS report 2939-000011-18 submitted to the MOHLTC on a specific date. The report stated that resident #015 was observed being assaulted by resident #012 and then resident #015 experiencing a specific event and specific condition.

Resident #012 had a written plan of care that identified resistive/reactive behaviour of a specific nature related to a specific condition.

On a specific date, Personal Support Worker (PSW) #131 stated that they were aware of the responsive behaviours of resident #012 and that there were specific triggers for resident #012 and that the behaviours were very unpredictable when resident #012 would react and to whom they would react. PSW #131 also stated that resident #012 was calm today, and that their one on one worker had been reassigned to a different home area

Resident Assessment Coordinator (RAI) #102 stated that there were two different progress notes in Point Click Care (PCC) for staff to utilize to document responsive behaviours, and were titled "Behaviour" or "Occurrence Note". RAI #102 stated that generally the behaviour note would be used for verbal interaction, and an occurrence note would be used for physical interaction. RAI #102 also stated that there was an assessment tool found in PCC that would be used by staff as a debriefing tool after an incident of new or changed responsive behaviours to look for triggers, effective interventions and required updates to the plan of care.

The clinical record for resident #012 was reviewed between the dates of the two CIS reports submitted to the MOH, finding 17 documented behaviour notes of verbal interaction of resident #012 with other residents or staff, and an additional 8 behaviour notes since the submission of the most recent CIS. Also noted were 4 documented occurrence notes of physical or the threat of physical interaction to other residents and staff, and 7 additional occurrence notes since the submission of the most recent CIS. The clinical record of resident #012 only included four documented Responsive Behaviour de-brief notes since admission and up to present.

Review of the clinical record for resident #012 included documentation of the following additional resources and assessments being initiated to address the responsive behaviours of resident #012.

A referral request for the external Behavioural Supports Ontario (BSO) was initially completed on a specific date.

A Dementia Observation Study (DOS) was initiated on a specific date, and was noted to have not been completed by staff on a specific date during a specific time frame, and on another specific date, during a specific time frame.

An assessment was completed by the Geritric Mental Health Outreach Team (GMHOT) on a specific date.

A Mental Health Outpatient consult was completed by Physician #135 on a specific date.

Again on a specific date, GMHOT follow up identified previously identified interventions had not been implemented.

Follow up assessments were completed by GMHOT on a specific date, with specific interventions.

Follow up assessments were completed by GMHOT on a specific date, and noted to re-recommend interventions to be implemented that were suggested at the previous assessment, visit which had not yet been completed.

Follow up assessment by GMHOT on a specific date, noted that not all previous recommendations had been implemented.

A Dementia Observation Study (DOS) was initiated on a specific date, and was noted to have not been completed by staff on a specific date during a specific time frame.

A Dementia Observation Study (DOS) was initiated on a specific date, and was noted to have not been completed by staff on two specific date during specific time frames.

Assistant Director of Care (ADOC) #101 stated that they were aware of the responsive behaviours of resident #012 and that multiple interventions were in place to address the responsive behaviours including one on one staff supervision. Inspector #537 noted to ADOC #101 that during observation and following interview with Personal Support Worker #110, on a specific date, resident #012 did not have a one on one worker. Inspector #537 shared the number of occurrence and behaviour notes that continued to be completed by staff as a result of the responsive behaviours of resident #012. Also, Inspector #537 reviewed the assessments and interventions that had been initiated by GMHOT which had not been followed up on, as well as the DOS assessments that had not been completed for resident #012. Also, was discussed that the ABS score for resident #012 had increased, indicating worsening of behaviours, and that there were only four documented Responsive Behaviour de-brief tools to evaluate the trigger, and effectiveness of current interventions or the need for different interventions. ADOC #101 stated that assessments and reassessments were not followed through and should have been.

The licensee has failed to ensure that the behavioural triggers for resident #012 were definitively identified, strategies were developed and implemented and followed through to respond to those behaviours, and actions were taken to respond to the needs of the resident, including reassessments. [s. 53. (4)]

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, for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, where possible; strategies are developed and implemented to respond to these behaviours, where possible; and actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Resident #005 was identified to have a medication order for a specific medication.

Review of the electronic Medication Incident Report and Analysis Form dated for a specific date, stated that the resident had been administered a specific medication at a specific time, on a specific date, by Registered Practical Nurse (RPN) #109.

The investigation notes revealed that RPN #109 had self-reported the error on a specific date, when it was discovered at shift change.

During an interview on a specific date, Director of Care (DOC #100), stated that on a specific date, resident #005 had received a full tablet of a specific medication and should have received a half tablet of the specific medication. DOC #100 acknowledged that the medication was not administered as per the directions of the ordering physician.

The licensee has failed to ensure that drugs were administered to resident #005 in accordance with the directions for use specified by the prescriber. [s. 131. (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 drugs were administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 13th day of September, 2018

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

Original report signed by the inspector.