Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 18, 2020	2020_747725_0007	014892-20, 016682-20, 016774-20	Critical Incident System

Licensee/Titulaire de permis

Chartwell Master Care LP
7070 Derrycrest Drive MISSISSAUGA ON L5W 0G5

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

CASSANDRA TAYLOR (725), ALICIA MARLATT (590)

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): September 8 and 9, 2020.

The following Critical Incident inspections were conducted:
Critical Incident Log #014892-20 / 2939-000024-20 - alleged improper care
Critical Incident Log #016682-20 / 2939-000030-20 - alleged improper care
Critical Incident Log #016774-20 / 2930-000031-20 - Injury resulting in hospitalization

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Assistant Director of Care, A Registered Practical Nurse, Personal Support Workers and a Personal Support Worker Instructor.

The inspector(s) also made observations of residents, resident and staff interactions and care and services. Reviewed relevant clinical records, investigative notes and plans of care for identified residents.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Personal Support Services
Reporting and Complaints

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	Légende 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 resident #001's care was provided as specified in the plan.

A resident required staff to assist with all care. A Personal Support Worker (PSW) provided care to the resident. When the PSW began providing care by means otherwise specified in the plan the resident was injured.

The staff not following the care plan resulted in minimal harm as the resident was injured from the incident.

Sources: Resident progress notes; care plan; MDS, and staff interviews with RPN and Director of Care. [s. 6. (7)]

2. The licensee has failed to ensure that resident #006's care was provided as specified in the plan.

A resident required staff to assist with all care. A Personal Support Worker (PSW) provided care to the resident. When the PSW began providing care by means otherwise specified in the plan the resident was injured.

The staff not following the care plan resulted in minimal harm as the resident was injured from the incident.

Sources: Resident's care plan; the LTCH’s investigative notes; interviews with the DOC and other staff members. [s. 6. (7)]

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 care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 21st day of September, 2020

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

Original report signed by the inspector.