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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
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130, avenue Dufferin 4ème étage
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 23, 2020	2020_563670_0035	023078-20, 023682-20, 023822-20	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

DEBRA CHURCHER (670)

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 7, 8, 9 and 10, 2020.

The purpose of this inspection was to inspect the following:
Log #023078-20 CIS#2939-000039-20 related to a fall with injury.
Log #023682-20 CIS#2939-000041-20 related to a fall with injury.
Log #023822-20 CIS#2939-000042-20 related to a fall with injury resulting in death.

Inspector #725 and #739 were onsite completing concurrent inspections.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care, one Registered Nurse, three Registered Practical Nurses, four Personal Support Workers and residents.

During the course of this inspection the Inspector observed the overall cleanliness and maintenance of the home, observed general infection control practices, observed staff to resident interactions, observed the provision of care, reviewed relevant clinical records, reviewed relevant internal documentation and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **2 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 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 :

The licensee has failed to ensure that they followed their policy related to their falls prevention program for resident #001, #006 and #007.

O. Reg. 48 (1) 1. states: "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home. A falls prevention and management program to reduce the incidence of falls and the risk of injury."

The home's policy related to falls prevention stated, head injury routine(HIR)/neurological assessment will be initiated for 48hrs if suspected head injury or unwitnessed fall unless otherwise directed by the attending physician.

The home's head injury flow sheet stated, unless otherwise ordered by the physician HIR is to be completed every 30 minutes for two hours, then every hour for the next four hours then every four hours until 24 hours post fall has been reached, then every eight hours until 48 hours post fall has been reached.

A) A progress note stated that resident #001 had experienced an incident.

The Inspector was unable to locate, and the home was unable to provide any Head Injury Routine documentation.

B) Progress notes dated for seven specific dates showed that resident #006 had experienced 15 separate incidents.

The Inspector was unable to locate, and the home was unable to provide any head injury

routine documentation for any of resident #006's incidents with the exception of one incident that had incomplete documentation.

C) Progress notes dated for two specific dates showed that resident #007 had experienced incidents on both dates.

The Inspector was unable to locate, and the home was unable to provide any head injury routine documentation for any of resident #007's incidents with the exception of one incident that had incomplete documentation.

During an interview with the Administrator #101 they stated that it would be the expectation that staff would complete a head injury routine as per the policy when required.

The homes failure to follow their policy related to falls prevention and management placed resident #001, #006 and #007 at risk for an undiagnosed and delayed diagnosis of a specific injury.

Sources: Resident #001, #006 and #007 clinical records, the homes police related to falls prevention and management and interview with the Administrator #101.

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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after resident #006 and #007 experienced incidents that resulted in significant changes in their health conditions for which they were taken to a hospital.

The licensee has failed to ensure that the Director was informed no later than one business day after resident #006 and #007 experienced incidents that resulted in significant changes in their health conditions for which they were taken to a hospital.

A) The home submitted a Critical Incident System report (CIS) on a specific date with an incident date listed as two days prior to the submission date related to an incident involving resident #006.

A progress note dated for the date of the incident showed that resident #006 had a significant change in condition related to the incident.

B) The home submitted a CIS on a specific date with the incident date listed as the same date as the CIS was submitted. The CIS was later amended to show that the incident had occurred three days prior to the CIS being submitted.

A progress note dated three days prior to the CIS submission date showed that resident #007 had experienced an incident that resulted in a change in condition.

During an interview with the Administrator #101 they acknowledged that the home had submitted both CIS reports late.

The homes failure to complete and submit CIS reports within the required time-frames placed resident #006 and #007 at risk.

Sources: Resident #006 and #007 clinical records and CIS reports and interview with Administrator #101.

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. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment.

A progress note related to an incident experienced by resident #001 stated that a specific piece of equipment did not function.

Interview with Administrator #101 where they stated that they had interviewed the Personal Support Worker (PSW) that cared for resident #001 on the date of the incident and they knew the equipment was turned on but were not sure why it did not function.

The homes failure to ensure that the equipment was functioning placed resident #001 at risk for injury.

Sources: Resident #001's clinical records and interview with Administrator #101. [s. 90. (2) (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 procedures are developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment, to be implemented voluntarily.

Issued on this 24th day of December, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Operations Division
Long-Term Care Inspections Branch

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBRA CHURCHER (670)
Inspection No. / No de l'inspection :	2020_563670_0035
Log No. / No de registre :	023078-20, 023682-20, 023822-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 23, 2020
Licensee / Titulaire de permis :	Chartwell Master Care LP 7070 Derrycrest Drive, Mississauga, ON, L5W-0G5
LTC Home / Foyer de SLD :	Chartwell Royal Oak Long Term Care Residence 1750 Division Road North, Kingsville, ON, N9Y-4G7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Nicole Ross

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 001

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 be compliant with O. Reg. 79/10 r. 8.(1). (b).
Specifically;
A) The licensee must ensure that the home's policy related to falls prevention is complied with.
B) The licensee must ensure that all Registered Nurses and Registered Practical Nurses receive re-training related to the home's policy related to completing a head injury routine for all residents that experience a fall when a head injury is suspected or the fall is unwitnessed.
C) The licensee must keep a record related to the training that indicates the content of the training, the staff members name that received the training and the date the training was completed.
D) The licensee must complete weekly audits of three falls (if available) to ensure that, if required, head injury routines are being completed at the specific time intervals listed in the homes policy. The audits will be completed for three months or until such time as compliance is achieved.
E) The licensee will keep records of audits completed, any deficiencies noted and any corrective actions taken related to identified deficiencies.

Grounds / Motifs :

1. The licensee has failed to ensure that they followed their policy related to their falls prevention program for resident #001, #006 and #007.

O. Reg. 48 (1) 1. states: "Every licensee of a long-term care home shall ensure

that the following interdisciplinary programs are developed and implemented in the home. A falls prevention and management program to reduce the incidence of falls and the risk of injury."

The home's policy related to falls prevention stated, head injury routine (HIR)/neurological assessment will be initiated for 48hrs if suspected head injury or unwitnessed fall unless otherwise directed by the attending physician.

The home's head injury flow sheet stated, unless otherwise ordered by the physician HIR is to be completed every 30 minutes for two hours, then every hour for the next four hours then every four hours until 24 hours post fall has been reached, then every eight hours until 48 hours post fall has been reached.

A) A progress note stated that resident #001 had experienced an incident.

The Inspector was unable to locate, and the home was unable to provide any Head Injury Routine documentation.

B) Progress notes dated for seven specific dates showed that resident #006 had experienced 15 separate incidents.

The Inspector was unable to locate, and the home was unable to provide any head injury routine documentation for any of resident #006's incidents with the exception of one incident that had incomplete documentation.

C) Progress notes dated for two specific dates showed that resident #007 had experienced incidents on both dates.

The Inspector was unable to locate, and the home was unable to provide any head injury routine documentation for any of resident #007's incidents with the exception of one incident that had incomplete documentation.

During an interview with the Administrator #101 they stated that it would be the expectation that staff would complete a head injury routine as per the policy when required.

The homes failure to follow their policy related to falls prevention and

management placed resident #001, #006 and #007 at risk for an undiagnosed and delayed diagnosis of a specific injury.

Sources: Resident #001, #006 and #007 clinical records, the homes police related to falls prevention and management and interview with the Administrator #101.

An order was made taking the following factors into account:
Severity: The home did not follow their policy related to falls prevention and management resulting in minimal harm and minimal risk to resident #001, #006 and #007

Scope: This issue was widespread as the home did not follow their policy related to falls prevention and management for resident #001, #006 and #007.

Compliance History: 18 Written Notifications, 15 Voluntary Plans of Correction and two Compliance Orders, which has been complied, were issued to the home related to different sub-sections of the legislation in the last 36 months. Two Written Notifications and two Voluntary Plans of Correction have been issued to the home related to the same subsections in the last 36 months.

(670)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 12, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
3. A missing or unaccounted for controlled substance.
4. Subject to subsection (3.1), an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10 r. 107. (3). 4.
Specifically;
A) The licensee shall complete education related to Critical Incident System (CIS) reporting requirements for any staff members that have access to complete a CIS.
B) The licensee shall keep record of the content of the education, the name of all employees educated and the date of the education.
C) The licensee will ensure that all required CIS reports are completed and submitted within the required time-frames.

Grounds / Motifs :

1. The licensee has failed to ensure that the Director was informed no later than

one business day after resident #006 and #007 experienced incidents that resulted in significant changes in their health conditions for which they were taken to a hospital.

A) The home submitted a Critical Incident System report (CIS) on a specific date with an incident date listed as two days prior to the submission date related to an incident involving resident #006.

A progress note dated for the date of the incident showed that resident #006 had a significant change in condition related to the incident.

B) The home submitted a CIS on a specific date with the incident date listed as the same date as the CIS was submitted. The CIS was later amended to show that the incident had occurred three days prior to the CIS being submitted.

A progress note dated three days prior to the CIS submission date showed that resident #007 had experienced an incident that resulted in a change in condition.

During an interview with the Administrator #101 they acknowledged that the home had submitted both CIS reports late.

The homes failure to complete and submit CIS reports within the required time-frames placed resident #006 and #007 at risk.

Sources: Resident #006 and #007 clinical records and CIS reports and interview with Administrator #101.

Severity: The home did not complete required CIS reports within the required time-frames resulting in minimal risk to resident #006 and #007

Scope: This issue was a pattern as two of the three CIS reports inspected were not completed within the required time-frames.

Compliance History: 20 Written Notifications, 17 Voluntary Plans of Correction and two Compliance Orders, which has been complied, were issued to the home related to different sub-sections of the legislation in the last 36 months.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

(670)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Apr 12, 2021

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 23rd day of December, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Debra Churcher

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