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
Jul 13, 2021	2021_791739_0027	005563-21, 005868-21, 006827-21, 007206-21, 007552-21, 008095-21	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

JULIE DALESSANDRO (739), CASSANDRA TAYLOR (725), 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): June 8, 9, 10, 11, 14, 15, 16, 17, 18, 21, 22, 23, and 24, 2021

During the course of this inspection the following intakes were completed:
Related to alleged abuse:
Log #005868-21/CI #2939-000016-21
Related to falls prevention:
Log #005563-21/CI #2939-000015-21
Log #006827-21/CI #2939-000018-21
Log #007206-21/CI #2939-000020-21
Log #007552-21/CI #2939-000021-21
Log #008095-21/CI#2939-000022-21

During the course of this inspection the inspector(s) also completed an infection control inspection and safe and secure home inspection.

During the course of the inspection, the inspector(s) spoke with Resident(s), a Screener, Housekeeper(s), Personal Support Worker(s), Registered Practical Nurse (s), Registered Nurse(s), the Environmental Services Manager, Assistant Director of Care, and Administrator.

During the course of this inspection the inspector(s) also conducted observations and record review relevant to the inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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 O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

The licensee had failed to ensure that the substitute decision makers for two residents were notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse.

A Critical Incident (CI) was submitted to the Ministry of Long-Term Care related to staff to resident abuse. At the time of the CI submission the names of the resident's were not know. An amended CI was submitted with three residents identified as being the residents involved.

After the CI was submitted it had been amended several times to include updated information however each time it was amended it continued to read that the substitute decision makers (SDM's) for the three residents were not notified of the alleged abuse.

During an interview with the home's administrator they stated that SDM's for two out of three residents had not been informed of the incident of alleged abuse.

Not notifying the SDM of alleged abuse posed a risk to the residents involved.

Sources: CI and an interview with the home's Administrator.

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 substitute decision makers are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of verbal abuse, to be implemented voluntarily.

Issued on this 14th day of July, 2021

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

Original report signed by the inspector.