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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 30, 2018	2018_617148_0036	029473-17, 016354-18, 016828-18, 022371-18	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 Lancaster Long Term Care Residence
105 Military Road North P.O. Box 429 LANCASTER ON K0C 1N0

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

AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 19, 20, 21 and 23, 2018

This inspection included four critical incident reports (CIR): three related to the elopement of two identified residents (Log 016354-18/CIR #2680-000006-18, Log 016828-18/ CIR #2680-000005-18 and Log 022371-18/ CIR #2680-000008-18); and one log related to suspected improper/incompetent treatment of five identified residents.

During the course of the inspection, the inspector(s) spoke with the home's Administrator/DOC, Assistant Director of Care, Registered Nurses, Personal Support Workers and residents.

The Inspector observed the resident care environment including exterior door security, observed resident care and observed resident to resident and staff to resident interactions. In addition, the Inspector reviewed identified resident health care records, licensee investigation documents and internal incident reports related to the identified critical incidents.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

The licensee has failed to ensure that there was a written plan of care for each resident that sets out, the planned care for the resident.

The plan of care for resident #001 related to responsive behaviours indicates the resident wanders, and has verbal and physical aggressions; behaviors are identified to be heightened at a specific time of day. In review of the critical incident report submitted to the Director, in addition to interviews with staff, the resident is to be provided with an increased level of supervision at a specified time of day. It was determined that during a specified period of time, on an identified day, the resident exhibited responsive behaviour and the increased level of supervision was not provided.

In discussion with the home's Administrator, the resident has been identified as requiring a described level of supervision and that the resident's responsive behaviours respond well to this intervention. Since the incident whereby the resident exhibited responsive behaviour the directions to staff on the implementation of the supervision have been revised.

At the time of the identified incident and at the time of this inspection the planned provision of supervision for resident #001 was not set out in the plan of care.
(Log 022371-18)

The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

The home's Administrator submitted two critical incident reports to the Director describing that on two separate dates, resident #002 had left the home without the staffs awareness. The resident's plan of care was updated after the second incident, to include the resident's risk of elopement.

The critical incident report and the home's investigation into the incidents, described that the resident was known to exit seek and had been seen leaving the building twice prior to the first reported incident. The health care record demonstrated a progress note and the use of medication describing the resident as exit seeking; each dated prior to the first reported incident.

In review of the archived plans of care, it was demonstrated that prior to the first reported incident, that the resident's care plan did not include the resident's exit seeking and/or elopement risk.
(Log 016354-18 and 016828-18)

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 written plan of care for each resident sets out the planned care for the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

The licensee has failed to ensure that all doors leading to the outside of the home, other than doors leading to secure outside areas that preclude exit by a resident, must be kept closed and locked.

On a specified date, the home's Administrator submitted a critical incident report to the Director related an incident of a missing resident. The report described that resident #001 was found outside of the building; the resident was brought back to the home without any injury. The home's investigation into the incident discovered that a door leading to the outside of the home was not locked. A door release panel near this same door had been engaged releasing the door locking mechanism.

On a specified date, a door leading to the outside of the home was not locked, for an unspecified period of time.
(Log 022371-18)

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 all doors leading to the outside of the home must be kept closed and locked, to be implemented voluntarily.

Issued on this 6th day of December, 2018

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

Original report signed by the inspector.