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
Feb 6, 2019	2019_538144_0003	010634-17, 010780-17, 010782-17, 011938-17, 003677-18, 004491-18, 005853-18, 006638-18, 009057-18, 017375-18, 024695-18, 025761-18, 026818-18, 032130-18, 000501-19	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 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

CAROLEE MILLINER (144), ALICIA MARLATT (590), TERRI DALY (115)

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): January 24, 25, 26, 28, 29, 30, 31, February 5, 2019.

The following intakes were inspected during this inspection:
Log # 010634-17, CIS # 2939-000018-17 related to prevention of abuse and neglect
Log # 010780-17, CIS # 2939-000019-17 related to transferring and positioning
Log # 010782-17, CIS # 2939-000016-17 related to transferring and positioning
Log # 011938-17, CIS # 2939-011938-17 related to skin and wound care
Log # 003677-18, CIS # 2939-000005-18 related to prevention of abuse and neglect
Log # 004491-18, CIS # 2939-000006-18 related to infection control and prevention
Log # 006638-18, CIS # 2939-000007-18 related to infection control and prevention
Log # 005853-18, CIS # 2939-000009-18 related to transferring and positioning technique
Log # 009057-18, CIS # 2939-000042-16 related to plan of care
Log # 017375-18, CIS # 2939-000012-18 related to falls prevention and management
Log # 024695-18, CIS # 2939-000015-18 related to infection prevention and control program
Log # 025761-18, CIS # 2939-000018-18 related to plan of care and falls prevention and management
Log # 026818-18, CIS # 2939-000020-18 related to prevention of abuse and neglect
Log # 032130-18, CIS # 2939-000024-18 related to medication management system
Log # 000501-19, CIS # 2939-000002-19 related to falls prevention and management

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, four Registered Nurses, five Registered Practical Nurses and nine Personal Support Workers.

During the course of the inspection, the inspector(s) observed and or spoke with twelve residents and reviewed sixteen resident clinical records and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 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. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident at risk of exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to a potential situation of improper treatment of a resident.

Review of one resident clinical record revealed that the resident underwent a procedure which required treatment and monitoring in the subsequent weeks.

Review of the resident progress notes showed the following entries after completion of the residents' procedure:

One Registered Practical Nurse (RPN) observed that there were no physician follow-up orders related to the the residents' procedure.

A family member of the resident expressed concern related to follow-up care after the procedure.

A progress note included that a specific assessment had been completed post procedure.

Review of the resident's clinical record showed that the specific assessment had been completed on the ninth day after the procedure.

During interviews, one RPN and one Registered Nurse (RN) shared that with this type of

procedure, registered staff were required to complete an assessment and that orders would need to be reviewed and approved by the homes' physician.

The RPN and RN further shared that the residents' clinical record should be updated to reflect the care orders and that the resident should have been assessed at the earliest possible time, depending on the physicians' orders.

The Director of Care (DOC) shared that the home completed an investigation into this matter and that the staff member involved, was re-educated.

The DOC said that the home's policy did not speak to assessing residents in this situation but considering the residents' procedure, they (DOC) expected that staff would complete an assessment or at least notify the next shift if they did not have time to complete an assessment. [s. 50. (2) (a) (ii)]

Issued on this 6th day of February, 2019

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

Original report signed by the inspector.