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
Mar 4, 2021	2021_791739_0006	024950-20, 025036-20, 025098-20, 025211-20	Complaint

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)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 22,23,24,and 25,2021

**During the course of this inspection the following intakes were inspected:
Log #025098/IL-85842-LO/IL-86601-LO/IL-86568-LO related to medication management, falls, responsive behaviours, and alleged abuse**

**Related to alleged abuse:
Log #024950-20/ CI #2939-000046-20
Log #025036-20/ CI #2939-000047-20
Log #025211-20/ CI #2939-000049-20**

During the course of this inspection an infection control inspection was also completed.

During the course of the inspection, the inspector(s) spoke with Resident(s), Registered Practical Nurse(s), Registered Nurse(s), Food Services Supervisor, and the Administrator.

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

**The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours**

During the course of this inspection, Non-Compliances were issued.
- **4 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. 234. Staff records

Specifically failed to comply with the following:

s. 234. (1) Subject to subsections (2) and (3), every licensee of a long-term care home shall ensure that a record is kept for each staff member of the home that includes at least the following with respect to the staff member:
1. The staff member's qualifications, previous employment and other relevant experience.
2. Where applicable, a verification of the staff member's current certificate of registration with the College of the regulated health profession of which he or she is a member, or verification of the staff member's current registration with the regulatory body governing his or her profession.
3. Where applicable, the results of the staff member's police record check under subsection 75 (2) of the Act.
4. Where applicable, the staff member's declarations under subsection 215 (4). O. Reg. 79/10, s. 234 (1); O. Reg. 451/18, s. 4.

Findings/Faits saillants :

The licensee had failed to ensure that a record was kept for each staff member of the home that included at least the following with respect to the staff member:
1. The staff member's qualifications, previous employment and other relevant experience.
2. Where applicable, a verification of the staff member's current certificate of registration with the College of the regulated health profession of which he or she is a member, or verification of the staff member's current registration with the regulatory body governing his or her profession.
3. Where applicable, the results of the staff member's police record check under subsection 75 (2) of the Act.
4. Where applicable, the staff member's declarations under subsection 215 (4). O. Reg. 79/10, s. 234 (1); O. Reg. 451/18, s. 4.

The Long-Term Care Homes Act defines "staff", in relation to a long-term care home, as persons who work at the home, pursuant to a contract or agreement with the licensee.

A Critical Incident (CI) Systems report was submitted to the Ministry of Long-Term Care (MLTC) related to allegations of abuse toward a resident.

A record review of the home's internal investigation was completed, and it had identified that five Personal Support Workers (PSW's) were potentially involved:
PSW #107 and #108 who were regularly employed with the home
PSW #104, #105, and #106 who were agency staff employed by the home

The inspector requested staff files for the five identified PSW's and received the two files of the regularly employed PSW's and was told by the Administrator that the home did have the completed files for the three agency PSW's however they were unable to provide the requested documents.

Not keeping up to date staff records within the home provided for minimal potential risk to the resident.
Sources: CIS reports, staff files for PSW #107 and PSW #108 and staff interview.

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 a record is kept for each staff member of the home, to be implemented voluntarily.

WN #2: 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 had failed to ensure that the Head Injury Routine for a resident was completed in full, on two separate occasions, after a fall.

This finding was further evidence which supported compliance order #001 from inspection #2020_563670_0035 regarding O. Reg. 79/10 r. 8 (1)(b).

The resident was identified as having been at risk for falls and they had two falls, eight days apart, in one month.

A record review of Point Click Care (PCC) progress notes indicated that after both falls the resident had been started on Head injury routine, was transferred to the hospital and returned to the home however, the HIR was not continued.

Information on the HIR flow sheet used by the home included, “unless otherwise ordered by the physician HIR is to be completed every 30 minutes for the two hours, then every hour for the next four hours until 24 hours post fall has been reached, then every eight hours until 48 hours post fall has been reached”

During an interview with a Registered Practical Nurse they stated that when a resident had an unwitnessed fall a HIR was to be completed post fall.

During an interview with the Administrator they stated that the HIR should have been completed for both falls and it was the expectation that staff followed the policy.

Not completing the HIR posed a potential risk for an undetected change to a resident's status post fall with a potential head injury.
Sources: Point Click care progress notes, HIR flow sheet, as well as staff interviews.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident’s money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee had failed to ensure that an allegation of abuse reported by a resident was reported to the Director immediately.

This finding is further evidence to support compliance order #001 from inspection #2020_747725_0021 regarding s. 24. (1), CDD Jan 13, 2021.

A resident reported an allegation of abuse to a Registered Practical Nurse (RPN). The resident had stated that a male had touched her buttocks.

The RPN then reported it to a Registered Nurse and they reported the incident to the Administrator. The Administrator had stated that an internal investigation was completed, and they did not think that the incident was required to be reported to the Director of the Ministry of Long-Term Care.

Not reporting matters to the Director within the required time frame posed a minimal potential risk.
Sources: Point Click Care progress notes, HIR flow sheet and staff interview.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

The licensee had failed to ensure that all staff had received annual training related to the prevention of abuse and neglect.

A Critical Incident report was submitted to the Ministry of Long-Term Care on three separate occasions related to allegations of abuse toward a resident.

During a record review of the home’s mandatory education for the “Abuse prevention series” through their online learning platform, it was noted that 146 out of 176 staff members had completed the education.

During an interview with the Food Service Supervisor they confirmed that 30 staff members had not completed their mandatory education and should have.

Not completing mandatory education presented a potential minimal risk.
Sources: Surge Learning document, and staff interview.

Issued on this 4th day of March, 2021

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

Original report signed by the inspector.