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
Nov 4, 2021	2021_791739_0041	013007-21, 013265-21, 013764-21	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)

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): October 13-15, 18-21, 25-28, November 1 and 2, 2021.

The following intakes were completed during this CIS inspection:
Log #013265-21 and Log #013007-21, related to falls, as well as Log #013764-21, related to personal support services.

NOTE: A Written Notification related to LTCHA, s. 6(9) was identified in a concurrent inspection #2021_791739_0040 (Log # 011432-21) and issued in this report.

During the course of the inspection, the inspector(s) spoke with Residents, the home's Screener/Swabber, Personal Support Workers, Registered Practical Nurses, a Registered Nurse, an Assistant Director of Care, and the Director of Care.

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

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Pain
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **2 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. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

The licensee had failed to ensure that in making a report to the Director under subsection 23 (2) of the Act, the licensee included the names of all residents involved in the incident and the long-term actions planned to correct the situation and prevent recurrence of the alleged neglect of a resident by the staff that led to the report.

A Critical Incident (CI) System Report was submitted to the Ministry of Long-Term Care. The report indicated that there was alleged neglect toward multiple residents. The report stated that the names of the residents involved were unknown at the time. The report also indicated that the long-term actions planned to correct this situation and prevent recurrence were pending the results of an investigation.

During an interview with the home's Director of Care (DOC) they indicated that an investigation of the incident was completed however the CI was not amended.

The DOC acknowledged that the CI had not been amended to include the names of the nine residents involved in the incident or the long-term actions to prevent recurrence until several weeks after the incident.

Not amending the CI with the information required caused minimal harm to the residents.

Sources: CI report and interview with the DOC. [s. 104. (1) 2.]

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 in making a report to the Director under subsection 23 (2) of the Act, the licensee included the names of all residents involved in the incident and the long-term actions planned to correct the situation and prevent recurrence of the alleged neglect of a resident by the staff that led to the report, to be implemented voluntarily.

WN #2: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

The licensee had failed to ensure that the provision of the care set out in the plan of care for multiple residents was documented in Point of Care (POC).

The following is further evidence to support the order issued on July 13, 2021, during inspection #2021_791739_0026 which was complied during inspection #2021_791739_0039.

A) A Critical Incident (CI) System Report was submitted to the Ministry of Long-Term Care. The report indicated that there was alleged neglect by Personal Support Worker (PSW) #112 toward multiple residents.

A record review of the Documentation Survey Report in Point Click Care (PCC) for the residents had shown that there was missing documentation in POC related to care.

During an interview with PSW #100 they stated that when a resident was assisted with care each shift would have signed for it in POC when it was completed. PSW #100 stated that if it was not signed for then that documentation was missed.

During an interview with the Director of Care (DOC) they stated that during the course of their investigation, PSW #112 indicated that they had provided the care but had not completed the documentation. The DOC acknowledged that care for multiple residents was not documented in POC.

B) A complaint was received by the Ministry of Long-Term Care related to a resident's care (Complaint inspection #2021_791739_0040, Log #011432-21).

Record review of the resident's plan of care stated that, staff were to assist the resident with care as scheduled.

A record review of the home's Documentation Survey Report from PCC showed that on multiple occasions there was missing documentation in POC to indicate that the resident had been assisted with the scheduled care as per their plan of care.

During an interview with Personal Support Worker (PSW) #102 they stated that if there was no documentation then the staff member would have forgotten to document that care was provided.

During an interview with one of the home's Assistant Directors of Care (ADOC) they acknowledged that there was missing documentation on multiple occasions and stated that the expectation would have been that documentation was completed.

Not documenting care in POC posed risk to the residents as oncoming staff did not know when care was last provided.

Sources: CI report, Documentation Survey Report from PCC, interviews with PSW #100, an ADOC, and the DOC.

Issued on this 4th day of November, 2021

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

Original report signed by the inspector.