Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: March 7, 2023

Inspection Number: 2023-1423-0002

Inspection Type:
Complaint
Critical Incident System

Licensee: Chartwell Master Care LP

Long Term Care Home and City: Chartwell Royal Oak Long Term Care Residence, Kingsville

Lead Inspector	**Inspector Digital Signature**
Terri Daly (115)	Terri Daly Digitally signed by Terri Daly Date: 2023.03.24 10:51:35 -04'00'

Additional Inspector(s)
Cassandra Aleksic (689)
Julie DAlessandro (739)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 4, 6, 9, 10, 11 and 12, 2023.

The following intake(s) were inspected:

- The following intakes were completed in this inspection Intake: #00003799, CI#: 2939-000017-22, Intake: #00003800, CI#: 2939-000019-22, Intake: #00005933, CI#: 2939-000021-22, Intake: #00006858, CI#: 2939-000022-22, Intake: #00008986, CI#: 2939-000033-22, Intake: #00011607, CI#: 2939-000034-22 related to falls with injury.
- Intake: #00016854, CI#: 2939-000043-22 unexpected death of a resident.
- Intake: #00016918 Complaint concerns related to a resident's unexpected death.
- Intake: #00007121 Complaint concerns related to sufficient staffing and care and services concerns.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's plan of care was revised when their care needs changed.

A Critical Incident System (CIS) report was received by the Director on a specific date, related to an incident resulting in a significant change in condition for a resident.

A review of the resident's care plan in Point Click Care identified specific interventions that the resident required for safety.

On a certain date, the Inspector observed the resident and the resident's room, they identified that the interventions did not coincide with the care plan.

In an interview with Associate Director of Care (ADOC), they indicated that the resident's care plan was not up to date with their current interventions but would be updated. The plan of care for the resident was revised to reflect the residents' current interventions.

Sources
Resident's plan of care and Kardex, Interviews with staff.

Date Remedy Implemented: January 11, 2023
[689]

WRITTEN NOTIFICATION: Resident's Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 3.

The licensee has failed to ensure that a resident's rights were fully respected when staff were uncertain of the resident's specific decision/choice for their treatment noted in their plan of care.

Rationale and Summary
On a specific date, the resident was not provided with a specific treatment they had requested and that was documented in the resident's plan of care.

A review of a Critical Incident System (CIS) report submitted to the Ministry of Long-Term Care on a specific date for this resident identified that a specific treatment choice requested by the resident/resident POA was not respected.

During an interview a Registered Practical Nurse and Personal Support Worker both verified that a treatment specific to that resident was not respected and therefore not keeping with the resident's wishes.

A review of the resident's clinical records showed that the resident/resident's POA had signed for a specific treatment choice and that the licensee did not respect the resident's wishes.

Sources
A Critical Incident, resident clinical record – progress notes, interviews and Ambulance Call Report. [115]

WRITTEN NOTIFICATION: Sufficient Linen Supply

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 95 (1) (b)

The licensee has failed to ensure that the there was a sufficient supply of clean peri-cloths available in the home for use by residents and staff.

Rationale and Summary
A complaint was received by the Ministry of Long-Term Care on a specific date, which outlined concerns that there were not enough supplies provided to the home area to provide resident care, including peri-care supplies.

The home's policy titled "Laundry Protocols" stated that the home was to ensure that an adequate supply of quality linens was available and appropriately distributed to meet resident and staff needs.

During an interview the Administrator and Director of Care stated that concerns had been brought forward to management related to the availability of peri-care supplies. It was indicated that peri-care cloths were dispersed to the home areas in October and November 2022 and the expectation was that they were to be laundered post-use. The DOC stated that they had explained to the staff the reason for the low supply of peri-cloths, and that the home was attempting to order more, but it was a team effort to ensure they are laundered appropriately and not be thrown out. The DOC stated that in the interim, the home had ordered disposable peri-cloths while sourcing out peri-care supplies as cloth products had been on back order.

During an interview with a Personal Support Worker (PSW) they stated that they had a minimal supply of cloths for resident peri-care available in their home area for their shift. They informed the inspector that their home area received approximately 12 peri-care cloths at the beginning of their shift, which was an insufficient supply to complete peri-care for 32 residents. The PSW stated that they were not made aware if the home had a supply of disposable peri-care cloths for use. The PSW and Inspector observed that there were no additional peri-cloths in the linen closet or on the towel cart for use.

Inspector observed the laundry room area and spoke with a housekeeping staff member who stated that the linens were laundered and put onto carts for the upcoming shift. Each cart was observed to be labelled with the home area name. The inspector was informed that no additional supplies would be added to the carts at this time. When asked about peri-care cloths, the housekeeping staff member stated that they did not have many peri-care cloths returned to be laundered, and what supplies they had would be distributed between the carts. Inspector counted 17 peri-care cloths on the linen cart for Oak home area for the next shift. The staff member said they were not sure what happened to all the cloths but heard they may have been thrown out.

Inspector was assisted by a Registered Practical Nurse (RPN) to observe the overstock supply closet regarding the availability of disposable peri-care supplies. There were four cases of disposable wipes and no overstock of peri-care cloths.

The insufficient supply of peri-cloths available in the home was low risk as it did not impact the completion of the resident's personal care needs.

Sources
Observation of resident home areas; Laundry Protocols policy, and Interviews with PSW, RPN, Administrator and DOC
[689]

COMPLIANCE ORDER CO #001 Safe and Secure Home

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 5

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The Licensee has failed to comply with: FLTCA, 2021, s. 5.
Specifically, the licensee must:

a) Conduct a multidisciplinary documented assessment of the outdoor lighting in the home's courtyards to ensure these areas are adequately illuminated.
b) Keep a documented record of this assessment and the dates that any lighting was replaced.
c) The home will keep a documented record of daily outdoor lighting inspections per the home's policy.

Grounds
Non-compliance with: FLTCA, 2021, s. 5.
The licensee has failed to ensure that Chartwell Royal Oak long term care home was a safe and secure environment for its residents due to the lack of lighting in a specific courtyard.

Rationale and Summary
A Critical Incident System (CIS) report was received by the Director on a specific date, followed by a complaint related to an incident with a resident.

During the inspection it was found that the courtyard where an incident involving a resident had occurred had minimal lighting.

During an interview with the Environmental Services Manager (ESM), they noted that lightbulbs had been placed on order but not yet received and that the two lights directly above the two exit doors to the courtyard had been replaced the day after the incident involving the resident.

During staff interviews, staff noted safety concerns regarding the lack of lighting in the courtyard.

A review of Critical Incident and review of the resident's clinical record, progress notes indicated that there were safety concerns as there were no lights in the courtyard.

After review of the home's relevant policy, and interviews with staff, the outside area was concluded to be unsafe.

Sources
A Critical Incident, a resident's clinical record – progress notes, interviews and policies and procedures. [115]

This order must be complied with by March 8, 2023

COMPLIANCE ORDER CO #002 Doors in a Home

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 2.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The Licensee has failed to comply with O. Reg. 246/22, s. 12 (1) 2.
Specifically, the licensee must:

a) Ensure that a specific courtyard door leading to the secure outside area that preclude exit by a resident, must be equipped with a lock to restrict unsupervised access to those areas by residents.
b) Complete an audit of all exit doors leading to the secure outside area that preclude exit by a resident, to ensure they are equipped with a lock to restrict unsupervised access to those areas by residents.

Grounds
Non-compliance with: O. Reg. 246/22, s. 12 (1) 2
The licensee has failed to ensure a specific courtyard door leading to the secure outside area was equipped with a lock to restrict unsupervised access by a resident.

Rationale and Summary
A Critical Incident (CIS) System report was received by the Director, followed by a complaint related to an incident with a resident.

Upon observation of specific photographs taken by the Administrator several hours after an incident occurred with a resident, the Administrator and staff identified an access key to a specific courtyard door hanging on the wall beside the door in the pictures.

The Administrator and a Registered Staff Member both indicated during an interview that the key to

that specific courtyard door was hanging on the wall beside the exit door on the same date as the incident, and could be used to unlock the door to permit access.

A staff member also indicated during an interview that when they initially responded to the door alarm they found the courtyard door unlatched and when they pushed the door it clicked closed and the alarm reset.

During another interview a staff member indicated that they had reported to the former Administrator that the door was not closing and latching properly back in the spring/summer of 2022 and that once on a shift the door had blown open.

Records show a locksmith had been called to the home after the resident incident, to fix the courtyard door.

Sources
Work orders for doors, interviews, record review, photographs taken by the Administrator and provided to Inspector #115.
[115]

This order must be complied with by March 8, 2023

COMPLIANCE ORDER CO #003 Doors in a Home

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 12 (2)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The Licensee has failed to comply with O. Reg. 246/22, s. 12 (2).
Specifically, the licensee must:

a) Ensure that the home's written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents, is complied with.
b) The Administrator must develop a protocol for checking and monitoring outdoor courtyard doors that coincides with the home's policy. The protocol will include staff positions responsible for the checks and the documentation to support that the checks have been performed, identify any deficiencies, and follow up.

c) The home must provide education to staff responsible for checking outdoor courtyards that includes a specific list of doors to be checked.
d) The home will replace courtyard doors that show signs of wear that include not latching or locking properly, no longer fit the door frame to prevent drafts and potential incidents of not closing appropriately.

Grounds

Non-compliance with: O. Reg. 246/22, s. 12. (2).

The licensee has failed to comply with Chartwell Royal Oak's safety and security policy related to Outdoor Courtyard Use.

In accordance with O. Reg. 246/22, s. 11 (1) (b) the licensee is required to ensure that written policies and protocols were developed for the safety and security of the home and to ensure they were complied with.

Specifically, the Administrator did not comply with the Balcony Safety/Outdoor Courtyard Use policy no: LTC-CA-WQ-100-05-03, last reviewed January 2017.

Rationale and Summary

A Critical Incident (CIS) System report, followed by a complaint was received on a specific date related to a resident incident.

After review of the home's policy and an interview with staff, it was found that the home did not comply with their policy related to Outdoor Courtyard Use.

Sources

Record review including policy, a Critical Incident, interviews.
[115]

This order must be complied with by March 31, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.