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 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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 25, 2016	2016_30610a_0017	024204-16, 024206-16	Critical Incident System

Licensee/Titulaire de permis

859530 Ontario Inc. (operating as Jarlette Health Services)
c/o Jarlette Health Services, 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

Long-Term Care Home/Foyer de soins de longue durée

Royal Rose Place
635 Prince Charles Drive North WELLAND ON 000 000

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

IRENE SCHMIDT (510a)

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): August 16, 17, 18, 2016.

During this inspection, CI log #024204-16, log #024206-16, and log #024983-16 (inspected as complaint log #024730-16) were inspected.

During the course of the inspection, the inspector(s) spoke with residents, substitute decision makers, the Administrator, Director of Care (DOC), Co DOC, Restorative Care Coordinator, Education Coordinator, registered staff, and personal support workers (PSW). Clinical records and policy and procedures were also reviewed.

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

During the course of this inspection, Non-Compliances were issued.
- **3 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	Legendé 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

An identified resident was admitted to the home with no history of responsive behaviors. On an identified date, progress notes reported the resident threatened another identified resident. A referral was made to Behavioral Supports Ontario (BSO), and the resident was assessed. BSO recommended checks, to ensure the safety of co-residents. Review of the clinical record revealed the absence of documentation of checks. This was confirmed by the DOC. On another identified date, BSO completed another assessment of the identified resident, with knowledge of the resident's responsive behaviors. Documentation directed that five day dementia observation sheet (DOS) charting would be started to determine triggers. Review of the clinical record revealed there was no documentation for multiple periods of time over the next five days. The Education Coordinator and co DOC confirmed five day DOS charting had not been completed. The DOC confirmed care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change.

An identified resident was admitted to the home on a specified date. The admission assessment on that date, reported that the resident did not use any mobility aids. The care plan initiated on the day of admission, included two interventions, neither of which related to the use of mobility aids.
After admission, the resident experienced an unwitnessed fall. The post fall assessment documentation identified staff would ensure the resident was using their mobility aid when walking around. Subsequently, the resident was observed to be ambulating with a mobility aid. Review of the document the home referred to as the care plan, had not been updated to include that the resident should use a mobility aid when ambulating. The resident's plan of care was not revised when the resident's care needs changed. [s. 6. (10) (b)]

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 care set out in the plan of care is provided and that the plan of care is revised when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone in the home.
s. 19. (1)

A critical incident report was submitted by the home that reported resident to resident abuse on a specified date.
Review of clinical records revealed that an identified resident demonstrated cognitive impairment and had, on several occassions, threatened to physically harm the other resident. This was reported to several staff members over a period of several days and the plan of care directed that frequent checks would be undertaken for the identified resident. On a specified date, the identified resident physically assaulted the other resident. Review of the clinical record revealed the absence of documentation of the frequent checks for the identified resident. The DOC confirmed the checks had not been implemented.
The other resident was not protected from abuse by anyone in the home. [s. 19. (1)]

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 residents are protected from abuse by anyone in the home, to be implemented voluntarily.

WN #3: 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 :

1. The home's policy titled "Falls Prevention and Management - Program", version three, revised May 27, 2016, directed that, registered staff would ensure that a resident who had an unwitnessed fall, would have head injury routine initiated unless the resident was able to reliably communicate they did not hit their head.
An identified resident, with impaired cognition, experienced an unwitnessed fall on a specified date. The DOC confirmed that it would be their expectation staff would conduct head injury routine for this resident post fall, given impaired cognition and the absence of documentation that the resident was able to reliably communicate they did not hit their head. The home's policy was not complied with. [s. 8. (1) (a),s. 8. (1) (b)]

Issued on this 1st day of September, 2016

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

Original report signed by the inspector.