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

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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_0016	024730-16	Complaint

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), KELLY HAYES (583)

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): August 16, 17, 18, 2016

Included in this inspection are three complaints: log #-24730-16 (which includes CI log #024983-16), log #024933-16 and log #025266-16.

During the course of the inspection, the inspector(s) spoke with residents, substitute decision makers (SDM), the administrator, director of care (DOC), restorative care coordinator, registered staff, chef, dietary aides, and personal support workers (PSW). As well, clinical records, policy and procedures, were reviewed.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Sufficient Staffing

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	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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

An identified resident was admitted to the home from another facility where they had been a resident for a specified period of time. The SDM for the resident reported that they delivered records from the transferring facility, to the admitting staff at the home. The SDM reported that they requested the resident have several interventions implemented. Review of the care plan developed at the home the day of admission, revealed the absence of the interventions the SDM had requested. The SDM was not provided the opportunity to participate fully in the development of the resident's plan of care. [s. 6. (5)]

2. 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).

Review of the clinical record revealed that under the focus for risk of falls, hourly (Q1H) checks were identified as an intervention to ensure resident safety. This intervention was initiated at admission. Review of the clinical record on a date after admission, revealed the absence of the hourly checks for safety. The DOC confirmed that hourly checks, as set out in the plan of care, were not completed for this resident. [s. 6. (7)]

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 the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, and that care set out in the plan of care, is provided to the resident., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed, no later than one business day after the occurrence of, 4) an incident that caused an injury to a resident for which the resident was taken to hospital and that resulted in a significant change in the residents health condition.

On an specified date, an identified resident sustained a fall which resulted in injury. The resident was transferred to hospital where they received treatment for their injury. The resident experienced a subsequent change in their condition, and was returned to hospital. The critical incident (CI) report was submitted to the Director several days after the incident. The DOC confirmed that the Director was not informed within one business day of the incident, when there was an injury that resulted in a significant change in the resident's health condition. [s. 107. (3) 4.]

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.