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
May 29, 2020	2020_523461_0002	024077-19, 001315-20	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 Ballycliffe Long Term Care Residence
70 Station Street AJAX ON L1S 1R9

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

CRISTINA MONTOYA (461)

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): February 20, 21, 24-28, and March 2, 2020

The following intakes were completed in this Inspection:

Intakes related to resident falls and improper treatment were inspected.

During the course of the inspection, the inspector(s) spoke with the administrator, the Director of Care (DOC), Resident Assessment Instrument (RAI)-Coordinator, Skin and Care Coordinator, Falls Prevention Program Lead, Nurse Practitioner (NP), Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapist (PT), Registered Dietitian (RD), Physiotherapy Assistants, Personal Support Workers (PSW), and residents.

The inspector also reviewed residents' health care records, the licensee's relevant policies and procedures, observed the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 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 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care is provided to resident as specified in the plan.

A Critical Incident Report (CIR) was submitted to the Director related to an incident of improper/incompetent treatment to resident #001, which resulted in an altered skin integrity. The resident was referred to the Nurse Practitioner (NP) who ordered a specified treatment. On a specified date, while the resident was on a Leave of Absence (LOA), the resident's Substitute Decision Maker (SDM) notified the administrator that resident’s area of altered skin integrity had deteriorated.

A review of resident #001's health care records on specified dates, revealed that the registered nursing staff did not apply the treatment ordered by the NP as it was not available in the home.

Review of the resident's written plan of care initiated on a specified date, related to the altered skin integrity included the following interventions: apply treatment as ordered, monitor site daily for infection or changes to area, weekly skin assessment, and pain monitoring every shift.

During an interview with RPN #102, they indicated that on a specified date, the resident's altered skin integrity had deteriorated. The NP saw the resident and ordered a specified treatment. This treatment was not available in the home from the time it was ordered until resident #001 went for a LOA. The RPN indicated that they implemented an intervention, which was different from the treatment ordered by the NP. On a different specified date, the RPN asked the NP and RN #102 to assess the resident because the treatment ordered was not available, the NP ordered another treatment.

In an interview, the Skin Care Coordinator RN #103, indicated that they became aware of the incident when notified by RPN #102, that the treatment ordered by the NP was not available in the home. The RN requested the that DOC order the supplies required for the treatment which was ordered by the NP, and not available in the home.

In an interview with RPN #105, they indicated that they forgot to provide the resident's SDM with supplies required for the treatment when the resident left the home for a LOA.

During an interview, the DOC indicated that they did not remember the day or time when they were informed about the need for the treatment for resident #001's altered skin integrity. The DOC indicated that the home's expectation was for the registered staff to contact the DOC to order the treatment when the NP prescribed it. The staff was also expected to check with the pharmacist if the product was available. If pharmacy did not

carry the product, the registered staff should have called the physician for an alternative treatment. The DOC acknowledged that resident did not receive the treatment for the alteration in skin integrity as set out in the plan of care. (461) [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 care set out in the plan of care is provided to the residents as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to the interventions were documented, specifically related to the pain program.

A review of the home's Pain policy, which was part of the licensee's Pain and Palliative Care Program, stated that the staff will complete a comprehensive pain assessment tool when a resident reports new pain that is not episodic in nature, such as a headache, or an exacerbation of exiting pain that is not easily addressed with medication adjustment.

A CIR was submitted to the Director related to an incident of improper/incompetent treatment to resident #001, which resulted in harm or risk to the resident.

A review of resident #001's written plan of care indicated that the resident had identified

pain. The interventions included to administer medications as per physician's orders and staff to monitor pain, if pain levels increased in frequency or intensity. The resident's written plan of care for alteration in skin integrity related to the injury also included interventions to monitor pain at every shift.

A review of the resident's pain assessments revealed that the registered nursing staff did not complete a comprehensive pain assessment on specified dates, when the resident verbalized pain as directed in the home's pain policy.

During an interview with RN #106, they indicated that resident #001 was able to verbalize the level of pain. The RN acknowledged that on a specified date, they did not complete a comprehensive pain assessment when the resident verbalized pain after the incident.

During separate interviews with the Skin Care Coordinator RN #103, and the DOC, they acknowledged that any time a resident verbalized a new pain, the registered staff were required to complete a comprehensive pain assessment.

The DOC further indicated that every resident who was on a routine pain medication, a pain scale from zero to ten or a visual pain scale was implemented before the administration of such medication. However, the pain monitoring was separate from a pain assessment. In the event, a resident's pain worsened, the registered staff were expected to complete a comprehensive assessment, which was not completed when resident #001 verbalized a new pain.

The licensee failed to ensure that the registered staff completed a comprehensive pain assessment for resident #001 when a new pain was verbalized by the resident, which was a requirement under the licensee's pain and palliative care program. (461) [s. 30. (2)]

2. A CIR was submitted to the Director on a specified date, related to an incident that caused an injury to resident #002 for which the resident was taken to the hospital and resulted in a significant change in the resident's status.

A review of the CIR and health care records for resident #002, revealed that on a specified date, resident #002 was assessed by the home's physician for pain and a diagnostic test was ordered. The test revealed an injury on a specified body part for which the resident was sent to the hospital.

Review of the resident's written plan of care related to pain, indicated that the resident may have general aches and pain, and they may experience pain related to the recent injury. The interventions included to administer medications according to the physician's orders and staff to initiate pain monitoring, if pain worsened or if is a new pain.

A review of the resident's pain assessments revealed that the registered staff did not complete a comprehensive pain assessment on five identified dates, when resident #002 verbalized pain.

During an interview with RPN #102, they indicated that on a specified date, they were focused on the resident #002's pain on a specified body part, but not the new pain. The RPN indicated that they should have completed a comprehensive pain assessment on the specified date, when resident complained of a new pain.

During separate interviews with the Falls Prevention Program Co-Lead RN #113 and the DOC, by inspector #461, they acknowledged that any time a resident verbalized a new pain, the registered staff were required to complete a comprehensive pain assessment.

The DOC further indicated that when a resident's pain worsened, the registered staff were expected to complete a comprehensive assessment, which was not completed when resident #002 verbalized a new pain.

The licensee failed to ensure that the registered staff completed a comprehensive pain assessment for resident #002 when a new pain was verbalized by the resident, which was a requirement under the licensee's pain and palliative care program. (461) [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to the interventions were documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown pressure ulcers, skin tears or wounds had been assessed by a Registered Dietitian, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented.

According to the licensee's Wound Care Treatment policy, the residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or other wound will receive a referral to the Registered Dietitian (RD).

A CIR was submitted to the Director related to an incident of improper/incompetent treatment to resident #001, which resulted in an altered skin integrity. The resident was referred to the NP who ordered a specified treatment. On a specified date, while the resident was on a LOA, the resident's SDM notified the administrator that the resident's altered skin integrity had deteriorated.

A review of the resident #001's assessments revealed that on two specified dates, the registered staff did not initiate a referral to the RD when an altered skin integrity was

identified.

During an interview with RN #106, they indicated that registered staff were expected to send a dietary referral for residents exhibiting any alteration in skin integrity. The RN acknowledged that a referral to the RD was not submitted on a specified date, for resident #001.

During an interview, the home's RD, indicated that they were expected to receive a referral for any skin issues, but the RD did not receive a referral for resident #001 related to the altered skin integrity that occurred on a specified date.

In an interview with the Skin Care Coordinator RN #103 indicated that the registered staff should have sent a referral to the RD for resident #001's altered skin integrity.

In an interview with the DOC, they indicated that the registered staff were expected to send a referral to the RD for any alteration in skin integrity, but a referral to the RD was not completed for assessment of resident #001’s altered skin integrity.

The licensee failed to ensure that resident #001 who exhibited altered skin integrity was assessed by a Registered Dietitian. (461) [s. 50. (2) (b) (iii)]

2. A CIR was submitted to the Director related to an incident that caused an injury to resident #002, for which the resident was taken to hospital and resulted in a significant change in the resident’s status.

A review of resident #002's health records, revealed that on a specified date, the resident had an incident that resulted in an alteration of skin integrity. A referral to the RD was not initiated.

In an interview with the Skin Care Coordinator RN #103, they indicated that the registered staff were expected to send a referral to the RD for any alterations in skin integrity.

During an interview with the DOC, they acknowledged that the registered nursing staff did not send a referral to the RD for an assessment related to resident #002's altered skin integrity.

The licensee failed to ensure that resident #002 who exhibited altered skin integrity was

assessed by a Registered Dietitian. (461) [s. 50. (2) (b) (iii)]

3. The scope of the inspection was expanded to include resident #003 as non-compliance was identified related to resident #001 and #002, pertaining to the Registered Dietitian's assessment related to an altered skin integrity.

A review of resident #003's RD assessments revealed that the registered staff did not send a referral to the RD on two specified dates, when a skin alteration was assessed.

In separate interviews with the RAI-Coordinator and the DOC, both indicated that the registered nursing staff were expected to send a referral to the RD for any new alteration in skin integrity. The registered staff should have sent a referral to the RD when resident #003 exhibited altered skin integrity.

The licensee failed to ensure that resident #003 who exhibited altered skin integrity was assessed by a Registered Dietitian. (461) [s. 50. (2) (b) (iii)]

4. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

According to the licensee’s Wound Care Treatment policy, the appropriate assessment in Point Click Care will be initiated when there is an alteration in a resident’s skin integrity. This record is to be completed weekly by Registered Staff and is used to document specific information regarding areas of alteration as well as the treatment and healing of the affected areas.

A CIR was submitted to the Director related to an incident of improper/incompetent treatment to resident #001, which resulted in an altered skin integrity. The resident was referred to the NP who ordered a specified treatment. On a specified date, while the resident was on a LOA, the resident's SDM notified the administrator that resident’s altered skin integrity had deteriorated.

Inspector #461 reviewed resident #001’s health records on a specified date, the registered staff completed a skin assessment indicating that the resident had sustained an alteration of skin integrity. A review of the resident’s Treatment Administration Records (TAR) revealed that there was no documentation supporting the initiation of a treatment. Further review of the resident’s skin assessments showed that the registered

staff did not complete the weekly skin assessments to document the treatment and healing of the specified alteration of skin integrity.

A review of the resident #001's progress notes revealed that on a specified date, the resident sustained an alteration of skin integrity.

Review of resident #001's written plan of care related to the alteration in skin integrity, directed the staff to complete dressing daily as per TAR and apply a specified treatment as ordered. Inspector #461 identified that the NP did not prescribe the specified treatment until a number of days later.

A review of the resident’s weekly skin assessments on specified dates, showed that a weekly skin assessment was incomplete, and there was no weekly skin assessment for other identified skin alterations.

Inspector #461 reviewed the investigation initiated by the administrator on a specified date, related to the incident that resulted in resident #001's altered skin integrity. RPN #102 indicated that they were unable to apply the treatment because the supply was not available. On a specified date, RPN #102 completed the dressing, but did not follow the doctor's orders due to lack of supply. RPN #102 also did not complete the weekly skin assessment in its entirety as it did not include the status of the altered skin integrity. The administrator indicated that the RPN #102 did not follow the licensee's policy and procedures.

In an interview with RPN #102 further indicated, that they were pulled away to complete other tasks and was unable to fully complete the weekly skin assessment, which included the status of the altered skin integrity and the response to the treatment.

In an interview with the Skin Care Coordinator RN #103, they acknowledged that resident #001's weekly skin assessment done on a specified date was incomplete. RN #103 stated that they became aware of the resident’s altered skin integrity a number of days later after it had occurred, and it was the only time they had the opportunity to assess the resident. Unfortunately, the registered nursing staff did not fully complete the skin assessments for the resident according to the home's expectation.

In an interview with the DOC, they indicated that the registered staff were expected to complete an initial skin assessment for any alteration of skin integrity. The staff were to initiate a nursing measure or to communicate with the Skin Care Coordinator and

physician if they considered that further assessment was needed. They must complete a minimum of a weekly skin assessment and document the status of the alteration in skin integrity. When the initial assessment was completed, the registered staff were required to add an intervention in the resident's TAR to direct them to complete a weekly skin assessment. The DOC acknowledged that the registered nursing staff did not complete a minimum of a weekly skin assessment for resident #001's altered skin integrity.

The licensee failed to ensure that resident #001 who exhibited altered skin integrity was reassessed at least weekly by a member of the registered staff nursing staff. (461) [s. 50. (2) (b) (iv)]

5. A CIR was submitted to the Director related to an incident that caused an injury to resident #002, for which the resident was taken to hospital and resulted in a change in the resident's condition.

A review of resident #002's assessments on specified dates, revealed that on an identified date, the resident had a incident that resulted in an altered skin integrity. An initial skin assessment was completed, but interventions were not initiated to prevent further deterioration. There was no indication that the physician or the NP were notified to assess the resident.

A review of resident #002's written plan of care and TAR for a specified period of time, it did not include interventions to treat the alteration of skin integrity. The registered staff did not complete the weekly skin assessments. Additionally, the resident's progress notes did not indicate whether the resident's alteration in skin integrity was resolved.

A review of resident #002's initial skin assessment related to the resident's return from hospital, indicated that the resident had an altered skin integrity. Moreover, the registered staff did not complete weekly skin assessments for resident #002's on three identified dates.

Further review of resident #002's health records revealed that on an identified date, the condition of the affected area had deteriorated and a treatment was initiated. A comprehensive skin assessment was not completed to reflect the changes.

In an interview with the home's RAI Coordinator, they acknowledged that registered staff did not complete the weekly skin assessments to assess the status of the resident's altered skin integrity. The staff were required to complete a skin assessment and

document that the altered skin integrity had resolved. The RAI coordinator indicated that a skin assessment was not completed for resident #002.

In an interview with the home's Skin Care Coordinator RN #103, they indicated that the registered staff were expected to complete a weekly skin assessment for all alterations in skin integrity. Once the initial skin assessment was completed, the registered staff were required to initiate a treatment on the resident’s TAR, update the written plan of care, notify the family, document a progress note, and initiate a weekly skin assessment. The RN further indicated that when staff completed any type of skin assessments, it was expected to describe the status of the alteration in skin integrity.

During an interview with the DOC, they acknowledged that the registered nursing staff did not complete weekly skin assessments for resident #002’s altered skin integrity.

The licensee failed to ensure that resident #002 who exhibited altered skin integrity was reassessed at least weekly by a member of the registered staff nursing staff. (461) [s. 50. (2) (b) (iv)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a registered dietitian who is a member of the staff of the home; and is reassessed at least weekly by a member of the registered staff nursing staff, if clinically indicated., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 142. Care during absence
Every licensee of a long-term care home shall ensure that before a long-stay resident of the home leaves for a casual absence or a vacation absence and before a short-stay resident of the home leaves for a casual absence,
(a) a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff of the home sets out in writing the care required to be given to the resident during the absence; and
(b) a member of the licensee's staff communicates to the resident, or the resident's substitute decision-maker,
(i) the need to take all reasonable steps to ensure that the care required to be given to the resident is received by the resident during the absence,
(ii) that the licensee will not be responsible for the care, safety and well-being of the resident during the absence and that the resident or the resident's substitute decision-maker assumes full responsibility for the care, safety and well-being of the resident during the absence, and
(iii) the need to notify the Administrator of the home if the resident is admitted to a hospital during the absence or if the date of the resident's return changer. O. Reg. 79/10, s. 142.

Findings/Faits saillants :

1. The licensee failed to ensure that before a long-stay resident of the home leaves for a casual absence, a physician or a registered nurse of the home sets out in writing the care required to be given to the resident during the absence.

A CIR was submitted to the Director related to an incident of improper/incompetent treatment to resident #001, which resulted in an altered skin integrity. The resident was referred to the NP who ordered a specified treatment. While the resident was on a LOA, the resident's SDM notified the administrator of a change in resident's altered skin integrity.

A review of the home's Leave of Absence with Medication policy, indicated that the registered staff will provide residents with all required medications during a leave of absence from the home; provide instructions for the administration of the medications;

document the medications and the administration directions provided to the resident/family/SDM on the Leave of Absence Responsibility Acceptance Form.

A review of resident #001's progress note on a specified date, RPN #105 documented that resident was on a LOA with SDM for a specified period of time, and medications were provided.

Review of resident #001's SDM communication sent to the administrator on a specified date, indicated that the SDM was concerned about the condition of the resident's altered skin integrity.

Inspector #461 reviewed resident #001's physician's orders and TAR, which indicated that on specified dates, the NP ordered two different treatments for the resident. One of those treatments was not available in the home.

Inspector #461 reviewed the home's investigation regarding the incident that resulted in the resident #001's altered skin integrity. It indicated that the RPN #105 did not provide the treatment to care for the resident's altered skin integrity to the family. The administrator indicated that the RPN had failed to follow the licensee's policies and procedures related to LOA.

In an interview with RPN #105, they indicated that on a specified date and time, the resident's SDM informed the RPN that they were taking the resident home. The RPN indicated that they did not provide written instructions or complete the home's LOA Responsibility Acceptance form with the SDM as per home's policy.

In an interview with RN #103, they indicated that any time a resident left the home on a LOA, the registered staff were required to complete the home's Leave of Absence Responsibility Acceptance form with instructions for medication administration and specified treatments. The RN was not aware that the resident went home without the instructions and supplies for the treatment until days later.

In an interview with the administrator, they indicated that on a specified date, the staff approached them indicating that resident #001 was being discharged. The administrator advised the resident's SDM to hold the discharge until all the supports for the residents were in place and suggested a LOA instead. On a specified date, while the resident was on LOA, the resident's SDM informed the administrator that the resident's altered skin integrity had deteriorated.

During the interview with the administrator, they acknowledged that the registered nursing staff did not complete the Leave of Absence Responsibility Acceptance form with the resident's SDM and they did not provide the supplies required for the treatment as prescribed by the NP.

The licensee failed to ensure that when resident #001 left the home on a leave of absence, a physician or a registered nurse of the home set out in writing the care required to be given to the resident during the absence. (461) [s. 142. (a)]

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 before a long-stay resident of the home leaves for a casual absence, a physician or a registered nurse of the home sets out in writing the care required to be given to the resident during the absence, to be implemented voluntarily.

Issued on this 26th day of June, 2020

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

Original report signed by the inspector.