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
Jun 30, 2020	2020_609569_0004	003396-20, 004265-20, 005147-20, 005905-20, 008118-20	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 London Long Term Care Residence
2000 Blackwater Road LONDON ON N5X 4K6

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

DONNA TIERNEY (569)

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): June 11, 12, 15, 16, 17, 18, 22, 23, 24, and 25, 2020.

The following intakes were completed during this inspection:
Intake log #003396-20 / Critical Incident #2919-000007-20 related to a fall;
Intake log #004265-20 / Critical Incident #2919-000008-20 related to a fall;
Intake log #005147-20 / Critical Incident #2919-000010-20 related to a fall;
Intake log #008118-20 / Critical Incident #2919-000013-20 related to a fall;
Intake log #005905-20 / Critical Incident #2919-000011- 20 related to an unexpected death.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care, a Registered Practical Nurse / Falls lead, a Registered Nurse, and a Personal Support Worker.
Relevant clinical records and reports for identified residents were reviewed, as well as relevant home policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

A Critical Incident (CI) related to an identified resident having an incident was submitted to the Ministry of Long-term Care (MLTC). The home submitted the CI under the category "Incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status."

Review of the identified resident's current written care plan outlined interventions for staff to follow that facilitated the resident's abilities and safety. The written care plan indicated that the resident was able to perform certain activities with staff to assist and / or supervise as needed. Other clinical records for the identified resident were also reviewed. These records indicated that the resident had significant limitations in those same activities and either needed full assistance by staff or not able to perform the activity at all.

A Personal support worker (PSW) was asked if the identified resident was able to perform the specific activities outlined in the resident's current written care plan . The PSW replied they were not. When the PSW was asked where they obtained information on a resident's care needs, they replied they get it from shift report, signage in a resident's room, the Kardex, and the printed care plan that is kept in a binder on the unit.

The Acting Director of Care (ADOC) when asked when changes are made to a resident's care plan, are the non-relevant interventions removed, they replied they should be. A Registered Practical Nurse (RPN) and the home's fall lead also said in an interview that if a task was changed or no longer required for any resident due to a change in their condition, that it should be removed from the resident's current care plan.

In additional interviews with the RPN/ fall lead, they affirmed that the identified resident was not able to perform certain specific activities as identified in their current written plan of care and therefore did not provide clear direction to staff.

The Licensee failed to ensure that the written plan of care for the identified resident set out clear directions to staff and others who provide direct care to the resident.

Issued on this 30th day of June, 2020

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

Original report signed by the inspector.