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

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Original Public Report

Report Issue Date: July 11, 2023

Inspection Number: 2023-1403-0003

Inspection Type:
Follow up
Critical Incident System

Licensee: Chartwell Master Care LP

Long Term Care Home and City: Chartwell London Long Term Care Residence, London

Lead Inspector	**Inspector Digital Signature**
Ina Reynolds (524)	Ina Reynolds Digitally signed by Ina Reynolds Date: 2023.07.12 13:05:10 -04'00'

Additional Inspector(s)
Julie Lampman (522)
Christina Legouffe (730)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 26, 27, 28, 29 and July 4, 2023.
The inspection occurred offsite on the following date(s): July 5, 2023.

The following intake(s) were inspected:

- Intake: #00015903 CI #2919-000044-22 related to Allegations of Neglect
- Intake: #00020126 follow-up to compliance order #001 from inspection #2022-1403-0001 related to FLTCA, 2021 s. 24 (1)
- Intake: #00020127 follow-up to compliance order #002 from inspection #2022-1403-0001 related to O. Reg. 246/22 s. 108 (1) 1
- Intake: #00020129 follow-up to compliance order #004 from inspection #2022-1403-0001 related to FLTCA, 2021 s. 6 (10) (b)
- Intake: #00020130 follow-up to compliance order #005 from inspection #2022-1403-0001 related to O. Reg. 246/22 s. 53 (1) 1
- Intake: #00088931 CI #2919-000029-23 related to Falls Prevention and Management
- Intake: #00020702 CI #2919-000007-23 related to Resident Care and Support Services.

The following intakes were also completed in this inspection:

- Intake: #00087627 CI #2919-000022-23 related to Falls Prevention and Management

- Intake: #00089763 CI #2919-000031-23 related to Falls Prevention and Management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2022-1403-0001 related to FLTCA, 2021, s. 24 (1) inspected by Julie Lampman (522)

Order #002 from Inspection #2022-1403-0001 related to O. Reg. 246/22, s. 108 (1) 1. inspected by Julie Lampman (522)

Order #004 from Inspection #2022-1403-0001 related to FLTCA, 2021, s. 6 (10) (b) inspected by Julie Lampman (522)

Order #005 from Inspection #2022-1403-0001 related to O. Reg. 246/22, s. 53 (1) 1. inspected by Julie Lampman (522)

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Involvement of Resident, etc.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee has failed to ensure that a resident's substitute decision-maker (SDM), were given an opportunity to participate fully in the implementation of the resident's plan of care.

Summary and Rationale
A Critical Incident report was submitted to the Director related to an allegation of neglect for a resident.

The Regional Director of Care (RDOC) spoke with the resident's Power of Attorney (POA) for care and the POA requested that the resident receive medical attention related to a decline in the resident's condition.

The RDOC directed a Registered Nurse to ensure the resident receive medical attention, but they did not.

The RDOC said that the Registered Nurse did not follow their direction, and therefore did not allow the SDM to fully participate in the implementation of the resident's plan of care.

There was a risk to the resident when the RN did not ensure the resident receive medical attention as requested by the SDM, when they were experiencing a decline in their condition.

Sources: Resident's clinical records, the home's investigation notes, interviews with the RDOC and other staff. [730]

WRITTEN NOTIFICATION: Licensee Must Investigate, Respond and Act

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (b)

The licensee has failed to ensure that appropriate actions were taken in response to an incident of improper care of a resident that resulted in harm or risk to the resident.

Summary and Rationale
A Critical Incident report submitted by the home documented that a resident sustained an injury related to an incident of improper care involving two staff members and later required medical treatment.

The home's policy titled "Head Injury Routine" stated that any resident who may have sustained injury to their head as a result of a fall or other such incident where the resident's head may have come in contact with a hard surface would have a head injury routine initiated. Registered staff were to assess the resident's blood pressure, pulse, respirations and pupillary reaction, level of alertness and orientation and ability to move upper and lower limbs. The staff were to document assessments as indicated on the Head Injury Flow Sheet and assess as per intervals of times required.

During a review of the resident's clinical records, there was no Head Injury Flow Sheet found. A staff member stated that they had initiated monitoring on the treatment administration record (TAR) and

blood pressure checks. The RDOC acknowledged a Head Injury Routine should have been initiated and staff had received education on March 21 and 23, 2023.

There was risk to the resident when they were not assessed for changes for the intervals of times required as per the home's Head Injury Routine policy.

Sources: A Critical Incident System report, the home's "Head Injury Routine" policy LTC-CA-ON-200-07-04, revision date January 2023, resident's clinical records, and interviews with the RDOC and other staff. [524]

WRITTEN NOTIFICATION: Reports of Investigation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (2)

The licensee has failed to ensure that the results of the investigation related to a resident were reported to the Director.

Summary and Rational
A Critical Incident report submitted by the home, documented that a resident sustained injuries as a result of an incident involving two staff members. The home conducted an internal investigation and follow-up actions were initiated with the staff members involved.

The amended Critical Incident report did not include the results of the investigation and stated, "Investigation is ongoing staff remain off pending investigation. Will update."

The RDOC acknowledged that the results of the investigation were not reported to the Director and should have been. Not reporting the results of the investigation to the Director posed a minimal potential risk.

Sources: A Critical Incident System (CIS) report and interviews with the RDOC. [524]

WRITTEN NOTIFICATION: Reporting to the Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred should have immediately reported the suspicion and the information upon

which it was based to the Director: Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

Summary and Rational
A Critical Incident report submitted by the home documented that a resident sustained injuries related to an incident of improper care involving two staff members and subsequently required medical treatment.

The RDOC said they were unaware of the incident at the time and acknowledged that the incident should have been reported immediately. Not reporting certain matters to the Director within the required time frame posed a minimal potential risk.

Sources: A Critical Incident report, a resident's clinical records, and interviews with the RDOC and other staff. [524]

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring and positioning techniques when transferring a resident.

Summary and Rational
A Critical Incident report submitted by the home documented that a resident sustained injuries during a transfer with an assistive device. Two personal support workers (PSWs) were present for the transfer. The resident subsequently required medical treatment.

The RDOC and a staff member both acknowledged the PSWs had not used safe transferring and positioning techniques when assisting the resident.

Sources: A Critical Incident report, resident's clinical records, and interviews with the RDOC and other staff. [524]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

A) The licensee has failed to comply with the home's falls prevention and management policy related to head injuries, included in the required falls prevention and management program in the home, for a

resident.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that written policies and protocols were developed for the falls prevention and management program and ensure that they were complied with. Specifically, staff did not comply with the licensee's "Head Injury Routine" LTC-CA-WQ-200-07-04 policy, revised August 2018.

Summary and Rationale
Review of the home's "Head Injury Routine" (HIR) policy stated that a head injury routine was to be initiated for any resident who may have sustained an injury to their head as a result of a fall or other such incident where the resident's head may have come in contact with a hard surface.

The HIR was to be performed every 30 minutes for the first two hours then every hour for the next four hours, then every four hours until 24 hours had been reached, then every eight hours until 48 hours post fall had been reached.

The home submitted a Critical Incident report related to a resident, which included concerns related to falls prevention and management. A resident sustained falls where HIRs were initiated.

Review of the resident's HIR flow sheets noted that not all the required checks were completed, and the documentation noted "sleeping" and "supper".

A Registered Nurse said that it was an expectation that all sections of a HIR were completed and that HIRs should be completed during a meal, unless a resident refused, and that it was not acceptable to document "sleeping" instead of completing a HIR.

The home's failure to follow their "Head Injury Routine" policy placed the resident at risk, as the staff had the potential to miss post fall injuries if regular assessments were not completed as required.

Sources: Review of a resident's clinical records, the home's "Head Injury Routine" policy LTC-CA-WQ-200-07-04 (Revised August 2018), and interviews with a Registered Nurse.

B) The licensee has failed to comply with the home's falls prevention and management policy related to physician notification, included in the required falls prevention and management program in the home, for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that written policies and protocols were developed for the falls prevention and management program and ensure that they

were complied with. Specifically, staff did not comply with the licensee's "Resident Falls Prevention Program" LTC-CA-WQ-200-07-08 policy, revised June 2022.

Rationale and Summary
Review of the home's "Resident Falls Prevention Program" policy stated that after a fall and if there was an injury, registered staff were to notify the physician of the incident and receive orders for additional medical treatment. This notification could be delayed until a reasonable hour of the morning if there was no significant injury.

The home submitted a Critical Incident report related to a resident, which included concerns related to falls prevention and management. The resident sustained a fall and required additional medical treatment for a suspected significant injury.

The clinical records for the resident stated that the physician was not notified about the resident's fall until the following day.

A Registered Practical Nurse (RPN) said that the physician should have been immediately notified when the resident required medical treatment for a suspected significant injury but was not.

Sources: A resident's clinical records, the home's policy "Resident Falls Prevention Program" LTC-CA-WQ-200-07-08 (Revised June 2022), and an interview with a RPN. [730]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to shall ensure that, a resident exhibiting altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Summary and Rationale
A Critical Incident report was submitted to the Director related to an allegation of neglect for a resident.

A resident sustained multiple falls which resulted in injury and areas of altered skin integrity. Not all weekly skin reassessments of the areas were completed.

A Registered Nurse said that the weekly skin reassessments should have been completed for the resident's altered areas of skin integrity but were not.

There was a risk that the resident's areas of altered skin integrity could have worsened in the absence of a weekly reassessment.

Sources: Resident's clinical record and interviews with a RN and other staff. [730]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)

The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control (IPAC) program related to contact precautions for a resident.

Summary and Rationale
During an observation, inspector observed a Personal Support Worker (PSW) providing continence care for a resident. The PSW was not wearing the required Personal Protective Equipment (PPE). Signage was posted on the door of the resident's room which indicated that they were on contact precautions.

Clinical records indicated that the resident was on contact precautions.

The home's policy titled "Routine Practices and Additional Precautions" said that for a resident on contact precautions that gloves, and a gown were required for activities that involved direct care including continence care, where the health care provider's skin or clothing may come in direct contact with the resident or items in the resident's room or bed space.

The IPAC Lead said that the PSW staff should have worn the required PPE while providing continence care.

There was a risk of harm to residents due to staff not donning the appropriate personal protective equipment prior to providing care to a resident under contact precautions.

Sources: The home's "Routine Practices and Additional Precautions" policy LTC-CA-WQ-205-03-07 (Revised October 2022), clinical records for a resident, and interview with the IPAC lead. [730]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. ii. A.

The licensee has failed to ensure that the complaint response to a resident's family member included an explanation of what the licensee had done to resolve the complaint related to the resident's infection.

Rationale and Summary
Compliance Order (CO) #002 from inspection #2022_1403_0001 was issued to the licensee on February 6, 2023. The CO stated that the licensee must ensure that the verbal complaint made by a resident's family member, regarding the care of the resident was documented, investigated, and a response provided to the resident's family member.

The complaint response letter to the resident's family member did not include what the licensee had done to resolve the complaint related to the resident's infection.

The Regional Director of Operations (RDO) stated that they were the Acting Administrator during the time of the investigation into the complaint. The RDO stated they had sent the written complaint response to the resident's family member and acknowledged that the response did not include what they had done to resolve the complaint that the home had not identified or treated the resident for a specific infection. The RDO stated they had forgotten to include in the complaint response letter that the staff had received education related to the specific infection.

Sources: Review of the home's investigation notes, the complaint response letter to a resident's family member and an interview with the RDO. [522]