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 # / No de registre	Type of Inspection / Genre d'inspection
Jun 18, 2018	2018_632502_0008	005378-18	Resident Quality Inspection

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

Chartwell Pine Grove Long Term Care Residence
8403 Islington Avenue North Woodbridge ON L4L 1X3

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

JULIENNE NGONLOGA (502), ADAM DICKEY (643), THERESA BERDOE-YOUNG (596)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): May 22, 23, 24, 25, 26, 28, 29, 31, June 1, 4, 5, and 6, 2018.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Assessment Instrument-Minimum Data Set (RAI-MDS), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Director of Social Work (DSW), Physiotherapist (PT) Food Service Manager (FSM), Registered Dietitian (RD), Dietary Aide (DA), Environment Services Manager (ESM), Housekeeping Aide (HA), residents, substitute decision-makers (SDMs) and family members of residents.

During the course of this inspection, the inspectors toured the home, observed resident care, observed staff and resident interactions, observed a resident medication administration, observed infection control staff practices, interviewed the Residents' Council (RC) and the Family Council (FC) presidents, reviewed the residents' health records, the meeting minutes, schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

7 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	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).

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 set out in the plan.

During stage two of the RQI resident #006 was triggered for specified condition from the most recent minimum data set (MDS) assessment.

Review of resident #006's MDS assessment and current written plan of care indicated that they were coded for a specified condition and symptoms which put them at high risk. Resident #006's care plan and the diet roster sheets indicated that they were to be provided with a specified food item daily at meals.

Observations by the inspector during a meal service revealed that resident #006 had completed their meal without receiving the above food item.

Review of resident #006's current written plan of care, indicated that the resident was at risk for a specified condition due to a specified symptom. Resident #006's care plan indicated that they were to be provided with a specified food item daily at meals. Review of the diet roster sheets in the servery, indicated that resident #006 was to receive the above mentioned item.

Observations by the inspector during a meal service revealed that resident #006 was served an entree at approximately 1212 hours, and had not been provided with the specific food item prior to receiving the entrée. At approximately 1235 hours resident #006 had completed their entrée and did not receive the above food item.

In an interview, staff #116 indicated that resident #006 was to receive the specified food item at meal service, however on the day of the observation, resident #006 had not received the food item as a the resident specified texture diet of the item was not

available on the unit during meal service. Staff #116 indicated that they could request it from another unit or the kitchen if not available on their unit. Staff #116 indicated that resident #006 did not receive the specified food item as the food item was not available in the appropriate diet texture.

In an interview, staff #118 indicated that when dietary staff do not have a food item available, the home expectation is that they call to the kitchen and get the item so it was possibly an oversight on the part of staff #116. [s. 6. (7)]

2. Due to identified noncompliance with LTCHA 2007, c. 8, s. 6. (7), the sample of residents was expanded to include resident #018.

Review of resident #018's current written plan of care and the diet roster indicated that they were to receive a specified food item daily at meals.

Observations on an identified date and time revealed that resident #018 did not receive the specified food item. The Inspector asked resident #018 if they normally received the specified food item and they stated they did. Resident #018 was asked if they would like to receive it during that meal and they indicated they would like to have it.

In an interview, staff #127 indicated that resident #018 was supposed to receive the specified food item identified above daily at meal services as listed on the diet roster. Staff #127 was not sure if resident #018 was offered the food item that day. Interview with staff #128 indicated that resident #018 was not offered the food item that day.

In an interview, the Food and Nutrition Manager (FNM) indicated that it was the process in the home for staff to save the food item in the evening for residents who receive it at a specific meal service the next day. The FNM indicated that the expectation was to serve the food item to these residents on a daily basis as indicated in the plan of care and diet roster. The FNM acknowledged that as residents #006 and #018's written plan of care indicated they were to receive the food item daily and the food item was not offered that the care set out in the plan of care was not provided to the residents as set out in the plan. [s. 6. (7)]

3. During stage two of the RQI resident #001 was triggered for incontinence worse from the most recent MDS assessment filed.

Review of the MDS assessment completed on an identified date revealed that resident

#001 was continent of bladder on admission in the home.

Resident #001's continence level had deteriorated, and they wear a continent care brief that was effective in keeping them clean and dry.

Review of resident #001's most recent written plan of care revealed under bladder function focus that the resident was totally incontinent and was to be toileted every two hours and as needed (prn) with the assistance of two staff using the mechanical lift.

In an interview on an identified date and time resident #001 told the inspectors that sometimes they are incontinent in their brief, and confirmed that they were wet at the time of interview.

In an interview, staff #104 stated that resident #001 wet heavily when they have an episode of incontinence. The staff stated that early on that day, the night shift staff had changed the resident before the end of the shift, and then they had assisted staff #103 to change the resident at the beginning of their shift. Staff #104 stated the resident should have been changed two hours later but was not sure if staff #103 had changed them.

In an interview, staff #103 stated that resident #001 was incontinent and acknowledge that the resident was to be checked and changed every two hours. Staff #103 stated that they usually changed the resident continence care product in the morning and after lunch as they do not have enough time to toilet everyone before lunch. They indicated that resident #001 is incontinent of bladder and continent of bowel. Staff #103 confirmed that they had not checked or changed the resident continence care product since the beginning of their shift on that day, which was three hours.

Staff #133 acknowledged that staff had not followed the plan of care as they had not checked or changed the resident continence care brief every two hours.

Staff #132 stated that the home expectation was for staff to check and toilet the resident every two hours and in between the scheduled time of two hours, and as needed. [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 was provided to the resident as set out in the plan, to be implemented voluntarily.

WN #2: 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 licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

As a result of non-compliance found for resident #010 related to altered skin integrity, the resident sample was expanded to include resident #019.

According to O.Reg 79/10, s, 48. (1), every licensee of a long-term care home shall ensure that a skin and wound care program to promote integrity, prevent the development of wound and pressure ulcers, and provide effective skin and wound care interventions is developed and implemented in the home.

The home's policy titled Wound Care Treatment, policy # LTC-CA-WQ-200-08-03, with a revision date of December 2017, under the assessment section, indicated: upon discovery of an alteration, staff will use the skin- initial skin and wound in point click care (PCC) to initiate a baseline assessment. Thereafter, the appropriate assessment will be

used in PCC for weekly assessment. -Skin- weekly skin tear
-Skin- weekly other
-Skin- weekly pressure ulcer
-Skin- weekly leg ulcer
-Skin- weekly diabetic foot ulcer.
Each assessment contains clinically relevant information to be used to determine the status of the alteration. Resident with stage 2 or greater pressure ulcers, leg ulcers and diabetic foot ulcers will have their wounds assessed weekly by the home's Skin Care Coordinator or designate.
Record review of resident #010's admission assessment indicated that the resident had an altered skin integrity.

Record review of the resident #019's weekly altered skin integrity assessment indicated: a description of condition of altered skin integrity. Review of the physician's order indicated weekly order skin alteration assessment .

Review of resident #019's skin- weekly altered skin integrity assessment for an identified period did not include a completed assessment for a specified date.

Staff #107 reported that they were the only registered staff that work on the floor on a specified date and somehow missed completing the resident's weekly assessment in PCC.

DOC suggested a re-interview with staff #107 as the missing assessment was completed manually on paper. During re-interview, staff #107, in the presence of staff #122 stated that they think they completed the resident's weekly assessment on the specified missing date, using a form titled ET/Woundcare specialist referral form, under the wound description section, on an identified date.

Record review of the ET/Woundcare specialist referral form did not include a date. [s. 8. (1) (a),s. 8.(1) (b)]

2. According to O.Reg 79/10, s.114 (2), every licensee of a long-term care home shall ensure that written policies and protocols are developed for the medication management system, to ensure the accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

The home's Classic Care pharmacy policy titled medication disposal, policy number 5.8,

with a revision date of July 2014 indicated that the pharmacy encourages that the home routinely inspects all medication storage areas, perhaps monthly, for the ongoing identification, destruction and disposal of expired drugs.

On an identified date during the review of the contents of a medication cart on the first floor, the inspector discovered a bottle of a specified medication with an expiry date of two months.
Staff #110 stated that the above mentioned expired medication should have been removed from the medication cart and given to the Nurse Manager.

Interview with the DOC indicated that the above mentioned expired medication should have been removed from the medication cart and placed in the drug destruction bin stored in the basement of the home. [s. 8. (1) (b)]

3. The home's pharmacy provider, Classic Care pharmacy's policy, titled administration and documenting controlled substances with a revision date of December 2016, indicates that the controlled substance medication should be initialed as administered, on the MAR in the correct box, immediately after administration and before the next resident is medication. Each dose of every controlled substance is accounted for on an individual narcotic sheet/record and MAR sheet.

Review of the double locked narcotic bin contained in the bottom drawer of the medication cart on an identified dated and time on a specified unit revealed:
1. Resident #013's medication blister pack that contained 20 tablets of a specified medication, and review of the resident's individual narcotic and controlled drug count sheet (RINCDC) indicated a count of 21 tablets with no staff sign offs on the same day.

Record review of resident #013's physician medication review dated on an identified date revealed an order for a specific medication was one tablet by mouth three times a day.

2. Resident #014's medication blister pack that contained 20 tablets of medication, and review of the resident's individual narcotic and controlled drug count sheet (RINCDC) indicated a count of 21 tablets with no staff sign offs for an identified date.

Record review of resident #014's physician medication review on identified date revealed an order for a specific medication one tablet by mouth every 8 hours while awake.

Interview with staff #110 reported that they administered the 0800 hours dose of

medication for resident #013 and resident #014 respectively earlier and planned to sign off on the RINCDC later. They stated that they should have signed off right away after administering the 0800 hours dose to the residents.

Interview with the DOC indicated that registered staff are expected to sign off on the EMAR as well as on the Resident's Individual Narcotic and Controlled Drug Count sheet after administering controlled substances to residents. [s. 8. (1) (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 that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, to be implemented voluntarily.

WN #3: 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 interventions were documented.

During stage two of the RQI resident #010 was triggered for altered skin integrity.

Record review of the resident's skin weekly altered skin integrity assessment for an identified period of time indicated that the resident had a specified altered skin integrity. The resident's current written plan of care stated that the resident required assistance

with bed mobility and should be turned and repositioned every two hours and as needed.

There was no documentation for turning and repositioning resident #010 every two hours on a specified date and time in point of care (POC).

Staff #105 reported that they had worked on the specified date and shift and had provided assistance to the resident with repositioning every two hours, but missed documenting the care in POC since they had worked short of staff on that day, and were very busy.

Interview with the DOC indicated that staff should provide resident #010 with the turning and repositioning assistance that they require as per the care plan, and complete the documentation in POC for care given; on the specified date the documentation was not completed. [s. 30. (2)]

2. As a result of non-compliance found for resident #010 related to altered skin integrity, the resident sample was expanded to include resident #012.
Record review of resident #012's physician order, indicated to discontinue all previous treatment orders. Record review of the resident's skin weekly altered skin integrity assessment, indicated altered skin integrity remains. Review of the resident #012's written care plan with the goal that the resident will not develop bed sores directed staff to provide total assistance, turn and reposition the resident every two hours in bed.

Record review of the resident's turning and repositioning documentation for an identified period of time did not include documentation for the specified date and times.

Interview with staff #128 reported that the resident was assigned to an agency staff on the day shift on the specified date, assisted the staff with turning and repositioning the resident every two hours, but did not document as the resident was not assigned to them.

The DOC reported that the staff who was assigned to the resident completed documentation manually using the home's flow sheet, but did not document turning and repositioning resident #012 every two hours, as there was no category for such documentation on the home's flow sheet. They stated that they will look at finding a way to capture turning and repositioning documentation for residents' with altered skin integrity who require it at a regular frequency, when agency staff use paper documentation as opposed to documenting in POC. [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 interventions were documented, to be implemented voluntarily.

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

During stage two of the RQI resident #010 was triggered for altered skin integrity

Record review of resident #010's plan of care indicated that resident #010 was admitted to the home with as specified skin alteration, and interventions included staff completing weekly skin assessments, and reporting significant findings to MD/NP.

Record review of resident #010's weekly altered skin integrity assessments for the specified skin alteration indicated that it was not completed on a specified date

Interview with staff #107 indicated that the resident had the skin alteration for a long time and it has changed in size and healing slowly. The staff stated that skin assessments should be completed weekly by registered staff for resident #010, they were responsible for completing it on a specific date, and missed doing it.

The DOC reported that weekly skin assessments should be completed for all residents with altered skin integrity. [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
- the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, and
- the resident who is incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent received an assessment that:
• includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and
• is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

During stage two of the RQI resident #002 triggered for incontinence from most recent MDS assessment.

Review of MDS assessment completed on an identified date, revealed that on admission resident #002 was moderately impaired with poor decisions, and required cues or supervision and they were continent of bowel and frequently incontinent of bladder and had consistently declined.

Review of the continence care assessment record documented on PCC had not identified a completed continence care assessment using the home's clinically appropriate assessment instrument on the specific dates when the resident level of continence had changed.

Review of the home's Continence Care policy #LTC-CA-WQ-200-02-05, revised on December 2017, indicated that registered staff will assess the level of urinary continence

of each resident as follows
- Upon admission to the home a fully five days assessment will be initiated,
- Quarterly as part of the resident quarterly review process. Any significant change in the continence status of the resident during the quarter will require a three day assessment, and
- Whenever there is a significant change in resident status.

In an interview, staff #118 indicated that the continence assessment should be completed on admission and whenever there is a change in continence care level. The staff was not able to provide a completed continence assessment for resident #002.

In an interview staff #116 and #122 stated that the continence assessment is completed by registered nursing staff on admission after five days observation period, quarterly thereafter, and when there is a change in continence status. After review the continence assessment record on PCC, both staff members acknowledged that the resident continence assessment was not completed using the home's clinically appropriate assessment instrument on admission and when the resident had a change in continence status. [s. 51. (2) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who required assistance with eating or drinking was not served a meal until someone was available to provide the assistance required by the resident.

Observations by the inspector on an identified date and time revealed resident #012 was012 was served a meal with no staff members available at the table to assist the resident. Resident #012 was seated at the dining table in their wheelchair and did not initiate feeding independently. Five minutes later staff #117 went to assist resident #012 and provided total feeding assistance.

Review of resident #012's current plan of care indicated that they required total assistance with eating from start to finish for meals and fluids related to specified condition.

In an interview staff #116 stated that a resident who requires assistance should not be served a meal until someone was available to assist the resident. The staff indicated that resident #012 was served a meal before staff were available to assist them. Staff #117 stated that resident #012 required extensive to total assistance at meals, and that someone should be available to assist the resident before they receive a meal. Staff #118 stated that residents who require assistance at meals should not be served a meal until someone was available to sit with them and provide the assistance required.

In an interview, the Food and Nutrition Manager (FNM) stated that it was the expectation of the home for residents who required total assistance with feeding should only be served once someone was available to assist them with feeding. The FNM acknowledged that for resident #012, who required assistance with eating and drinking was served a meal before someone was available to provide the assistance required by the resident. [s. 73. (2) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

On an identified date and time, the inspector observed staff #100 cleaning room #111, in which resident #011 was under specified condition and resident #004 was not. The inspector noted that the staff cleaned both sides of the room and the washroom without changing the gloves or performing hand hygiene.

In an interview staff #100 stated that they had used the same gloves while cleaning both side of the room and the washroom. They indicated that they should have changed the gloves after cleaning resident #011's side of the room as they were isolated for a specific infection.

In an interview staff #124 stated that the home expectation if for housekeeping staff clean the non-infected room first, change the cloth, gloves, and water, and then clean the room with a resident with confirm infection last. [s. 229. (4)]

Issued on this 29th day of June, 2018

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

Original report signed by the inspector.