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

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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
Sep 30, 2015	2015_289550_0021	O-002643-15	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

RESIDENCE CHAMPLAIN
428 Front Road West L'Orignal ON K0B 1K0

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

JOANNE HENRIE (550), AMANDA NIXON (148), LINDA HARKINS (126), LISA KLUKE (547)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 14, 15, 16, 17, 18, 21 and 22, 2015.

This inspection also included a complaint under OSAO Log O-001354-14, a critical incident under OASA Log O-001887-15 and a follow-up to a Compliance Order under OSAO Log O-001836-15.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Food and Nutrition Manager, Activity Director, Physiotherapist, MDS/RAI Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Food Service Workers, housekeeping aide, family and residents.

**In addition, the inspectors reviewed resident health care records, policies related to the
medication administration, staffing schedules, resident council minutes and family council minutes. Inspectors observed resident care and services, staff and resident interaction, and meal services.**

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

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

- **5 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #001	2015_381592_0005	148

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 is provided to resident #001 as specified in the plan.

Inspector #547 observed on three occasion that resident #001 had reddened skin with open areas to a specific body.

Inspector #547 interviewed PSW #S106 and RN #S100 who indicated that resident #001 requires specific interventions to protect his/her skin.

Inspector #547 reviewed resident #001's care plan and observed special interventions are documented to be put in place all the time for safety to prevent injuries to self. Inspector #547 did not observe that the specific interventions were put in place to protect the resident's skin.
[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 resident #001's care is provided as specified in her plan of care regarding skin integrity, to be implemented voluntarily.

WN #2: 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 when a resident is exhibiting altered skin integrity, including skin tears received 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.

Inspector #547 observed resident #001 during the lunch meal to have reddened inflamed skin on a specific body part.

Upon review of resident #001's health care records from a specific date in August 2015 to a specific date in September 2015, it was noted that no skin assessment was completed or any progress notes documented of any altered skin integrity during this period.

Interview with RN #S100 who is the skin and wound nurse for the home, indicated that resident #001 is prone to altered skin integrity with open areas to a specific body part. Specific interventions are usually put in place to prevent injuries to the resident. The resident should have been identified to her for skin assessment, as the skin was broken.

On September 18, 2015 Inspector #547 interviewed RPN #S102 who indicated that the morning report did not mention any open areas on resident #001's specific body part. [s.

50. (2) (b) (i)]

2. On a specific date in September 2015, resident #014 was observed to have a skin tear to a specific body part. It was covered with a Tegaderm dressing and it was observed to have a large amount of blood under the dressing.

Six days later, resident #014 was again observed to have a skin tear to the same body part. It was covered with a Tegaderm dressing and was observed to have a small amount of blood under the dressing. The Tegaderm dressing was changed recently and no documentation was found related to the change of the dressing and the condition of the skin tear in the resident's health records.

Discussion with RN #S103 indicated that the nurse who had applied the initial dressing should have completed a skin and wound assessment tool and an assessment of the skin tear should have been documented in the resident's progress notes. RN S#103 was unable to find documentation related to the recent dressing change and assessment of the skin tear. She indicated that the nurse who had applied the initial dressing was new to the home. [s. 50. (2) (b) (i)]

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 resident #001 and #014 who are exhibiting altered skin integrity, receive a skin assessment by a member of the nursing staff using a clinically appropriated instrument, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained. 2007, c. 8, s. 31 (2).
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
6. The plan of care provides for everything required under subsection (3).

Inspector #550 observed resident #13 on three different occasions sitting in a wheelchair. The resident had a padded tray table applied and the chair was tilted once.

Through staff interviews, it was established by Inspector #550 that the padded tray table for residents #013 was used as a physical restraint to prevent the resident from falling out of the chair either by leaning forward or sliding off and injuring himself/herself. Resident #013 was unable to remove this device and his/her movement was inhibited.

Inspector #550 reviewed the health care records for resident #013. The plan of care for the resident included the use of the physical devices as it related to positioning. The health care record did not include that the resident would suffer harm if not restrained, what alternatives had been considered, that the method of restraining was the least restrictive, or that a physician order for the devices to be used as restraints was obtained.

During an interview, the Director of Care indicated to inspector #550 the padded tray table was not assessed as restraint but as positioning aids. He indicated it is possible that since then the resident's condition has changed and that the resident was not re-assessed. Further to this, he confirmed that the requirements of section 31 of the Act were not met for the identified device. [s. 31. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

During the resident observation on September 15, 2015, it was observed by Inspectors #550 and #547 that the shared washroom between 2 specific rooms had a strong urine odour and there was no evidence of urine. It was again observed by Inspector #550 on September 17 and 18 the same shared bathroom had a strong urine odor.

During an interview on September 18, 2015, Housekeeping aide staff #S111 indicated to Inspector #550 that the housekeeping staff are assigned to clean this resident shared bathroom once a day and yet despite routine cleaning, this shared bathroom remains odorous.

During an interview, the Administrator who is the housekeeping manager indicated to Inspector #550 not being aware of the urine odor in this resident shared bathroom. After touring this bathroom herself, the Administrator/housekeeping manager confirmed the offensive odor in this shared resident bathroom. She indicated the procedure should have been that once the housekeeping aide staff identified the lingering offensive odor, she should have informed the Administrator/housekeeping manager. The Administrator/housekeeping manager would have then immediately informed the environmental manager for him to investigate and address the odor.

On September 18, 2015, Inspector #550 reviewed the home's policy and procedure regarding odour control. Although the Housekeeping Protocols policy and procedure indicated that a schedule is maintained for the cleaning and service to meet the need of the property, it failed to address and manage incidents of lingering offensive odors as identified in the resident shared bathroom between two specific rooms during the course of this inspection. [s. 87. (2) (d)]

WN #5: 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 by PSW staff by sharing an electric razor in the West tub room.

On a specific date in September 2015, Resident #31 indicated to Inspector #547 that he/she was shaved in the tub room with the home's electric razor that morning. Resident #31 indicated that he/she had his/her own razor, but staff use this razor for him/her with each tub bath that the resident gets twice a week. Resident was noted to have dry skin areas on a specific body part.

On a specific date in September 2015, PSW #S114 indicated to Inspector #547 that she bathed Resident #31 today, and used the home's tub room electric razor to shave the resident's specific body part and then washed it with a "Cavi" disinfectant wipe after each resident. PSW #S114 indicated that this razor is used with resident's who do not have their own razor in the home, and this resident preferred this razor as his/her own is not functioning properly.

On a specific date in September 2015, PSW #S112 providing baths to resident's today, indicated to Inspector #547 that the West tub room had an electric razor mainly for residents that did not have any of their own.

The Infection Prevention and Control leads in the home RN #S103 indicated to Inspector #547 that all resident's should have their own razors for personal use in the home, and if they do not have one, then they provide disposable razors to staff to use for these residents. RN #S103 indicated that she was not aware of this electric razor utilized in the West Tub room and that it is not to be used as a shared personal item for potential infection risk with the blades that could not be properly cleaned with the disinfectant wipes between residents.

During an interview, the Director of Care indicated to Inspector #547 that the "Cavi" wipes were not sufficient to clean razors as they would have to soak in a disinfectant solution for a period of time; and this cannot be achieved using the wipes. [s. 229. (4)]

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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

Issued on this 22nd day of October, 2015

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

Original report signed by the inspector.