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
Nov 30, 2021	2021_943988_0003	006323-21, 006703-21, 013043-21	Critical Incident System

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
7070 Derrycrest Drive Mississauga ON L5W 0G5

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

Chartwell Waterford Long Term Care Residence
2140 Baronwood Drive Oakville ON L6M 4V6

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

PARMINDER GHUMAN (706988), CAROLIN THOMAS (705120)

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): November 3, 4, 5, 8, 9, 10, 12, 15, 16 & 17, 2021

The following Critical Incident System (CIS) inspections were completed concurrently:
Log # 013043-21 related to fall with injury;
Log # 006703-21 related to alleged neglect of a resident; and
Log # 006323-21 related to improper care resulting in fall.

During the course of the inspection, the inspector(s) spoke with the Administrator, Directors of Care (DOC), Environmental Services Manager (ESM), registered dietitian (RD), dietary aide, Food Service Manager (FSM), occupational therapist (OT), physiotherapist (PT), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), family members and residents.

During the course of inspection the inspectors(s) toured the home, completed the Infection Prevention and Control (IPAC) checklist, observed resident care and meal service, relevant polices and procedures, relevant clinical health records and internal investigation notes.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

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

Staff transferred a resident using a transfer device and failed to complete the required safety check.As a result,the resident fell and sustained an injury.
During the home's internal investigation, a staff member confirmed that they had not completed the safety check prior to transferring the resident.
The DOC stated that the staff member missed a required safety check while transferring the resident using a transfer device.

As a result of the staff member failing to complete the safety check before transferring, the resident fell and sustained an injury.

Sources: The home's Internal Investigation Package; Interview with DOC and other staff.

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 staff use safe transferring and positioning devices or techniques when assisting residents, 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 :

2. The licensee has failed to ensure that a resident , who exhibited altered skin integrity, received an initial skin assessment using a clinically appropriate assessment instrument, was provided immediate treatment and interventions, was referred to the registered dietitian and received weekly skin assessments .

The licensee's skin assessment policy required registered staff to complete a skin assessment using a specific form, develop a resident-specific care plan, conduct other specific assessments related to skin and wound, weekly assessment of the area and referral to the registered dietitian (RD).

The resident's admission paperwork from the Local Health Integration Network (LHIN) identified a wound. During the resident's admission assessment, registered staff did not document any altered skin integrity for the resident. Approximately 24 hours later, a registered staff member documented that the resident had altered skin integrity. An initial skin assessment was not completed using the home's clinically appropriate tool, the resident did not receive immediate treatment nor were skin and wound interventions put in place. Over the next fifteen days, the condition of the resident's toe deteriorated and they were sent to the hospital.

The DOC confirmed registered staff did not complete an initial skin assessment of the resident's altered skin integrity, did not initiate weekly skin assessments, immediate treatment or interventions, and did not refer the resident to the RD.

Not ensuring the resident received an initial skin assessment, treatment and interventions, weekly assessments and RD referral may have contributed to the worsening of the resident's altered skin integrity.

Sources: DOC's investigative notes; care plan and electronic health record of resident ; Homes Skin Care Program Overview (LTC-CA-WQ-200-08-01); Interview with DOC's and other staff.

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 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, to be implemented voluntarily.

Issued on this 1st day of December, 2021

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

Original report signed by the inspector.