Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 26, 2019	2019_751649_0013	011207-19	Critical Incident System

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

Chartwell Wenleigh Long Term Care Residence
2065 Leanne Boulevard MISSISSAUGA ON L5K 2L6

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

JULIEANN HING (649)

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): July 9, 10, 12, 23, and off-site on July 25, 2019.

The following intake was inspected:
Log #011207-19/ CIS #2833-000003-19 related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the director of care (DOC), assistant director of care (ADOC), physician, nurse practitioner (NP), and registered nurses (RNs and RPNs).

The inspector reviewed residents' health records, staffing schedules, and relevant polices and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee had failed to ensure that staff and others involved in the different aspects of care, collaborated in the assessment of resident #001 so that their assessments were integrated, consistent with, and complemented each other.

A CIS report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) alleging that resident #001 was found on the floor, by a PSW. The resident complained of pain to an identified area and altered skin integrity was noted on second identified area. In a follow-up assessment the resident was transferred to hospital.

Further review of the CIS indicated that the resident returned from the hospital the same day and was diagnosed with an injury. Several medications were ordered including as needed (PRN) medication for pain.

(i) A review of the resident's electronic-medication administration record (e-MAR), progress notes, and pain medication effect for an identified date, indicated the lack of collaboration in the assessment of the resident's pain post injury when it was documented that their medication was not effective.

A review of progress note on an identified date written by RN #102 stated they had called the on-call physician (#104) to provide an update on the resident's condition. They were advised of certain orders including to continued with the existing pain medication.

In an interview with RN #102, they confirmed being aware that the resident's pain medication had not been effective in managing the resident's pain and explained that was their reason for calling the on-call physician (#104).

The on-call physician #104 told the inspector in an interview, that they were aware of the resident's injury and that the resident was on a PRN pain medication but had not received any concerns during the above call about the resident's pain. The physician further explained if they had been told about the resident's pain they would have inquired about the frequency of dosing of the PRN pain medication and would have questioned why the pain medication had not been optimized.

(ii) Further review of the resident's e-MAR, progress notes, and the pain medication for another identified date, indicated the lack of collaboration in the assessment of the resident's pain post injury when it was documented that the effect of the medication was unknown or not effective.

A review of progress notes indicated that the resident was assessed twice by the NP and stated that staff had informed them about the changes in the resident's condition and wrote orders to assess the resident's pain at identified intervals and to give the PRN pain medication.

In an interview with the NP they explained that they had assessed the resident but had not received any communication that the PRN pain medication had not been effective in managing the resident's pain and acknowledged not being aware of this. The NP told the inspector if staff were aware that the resident's pain medication was not effective in managing their pain the dose could have been changed.

In an interview with the ADOC #103 who was one of the staff involved in the processing of the above order written by the NP, confirmed that the above order to assess the resident's pain at identified intervals had not been transcribed to the resident's e-MAR. Since the order had not been transcribed to the resident's e-MAR their pain had not been reassessed as ordered.

In conclusion, the above two scenarios clearly demonstrate that the on-call physician and NP had not been collaborated with in the reassessment of the resident's pain medication when it was documented as not effective. [s. 6. (4) (a)]

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 staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident #002's written record was kept up to date at all times.

Resident #002 was selected for sample expansion related to non-compliance identified for resident #001.

A review of the resident's e-MAR indicated that a scheduled pain medication had not been signed as administered on an identified date.

The inspector requested a copy of the narcotic and controlled drug administration and shift count record for the above, mentioned date to further verify if the medication had been administered to the resident. The home told the inspector that they were unable to locate this record for resident #002.

In an interview with the DOC #105, they told the inspector that they had searched for the record but was unable to locate it for the above resident. [s. 231. (b)]

Issued on this 26th day of July, 2019

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

Original report signed by the inspector.