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
Jul 17, 2020	2020_738753_0015	002572-20, 005341-20, 006221-20, 009761-20	Complaint

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 Westmount Long Term Care Residence
200 David Bergey Drive KITCHENER ON N2E 3Y4

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

KATHERINE ADAMSKI (753), NUZHAT UDDIN (532)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 6-10, 14-15, 2020

The following intakes were completed in this Complaint Inspection:
Log #005341-20 and Log #009761-20 related to alleged abuse
Log #006221-20 and Log #002572-20 related to falls prevention and management

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Nurse Manager, Program Support Manager, Registered Nurses (RN), Physiotherapist (PT), Occupational Therapist (OT), Social Worker (SW), RAI Coordinator, Registered Practical Nurses (RPN), Residents, and Personal Support Workers (PSW).

The inspector's also observed staff to resident care provision and reviewed pertinent clinical records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #003 was being reassessed and the plan of care was being revised when care set out in the plan had not been effective, that different approaches had been considered in the revision of the plan of care.

Clinical record showed that resident #003 was admitted to the home on a specified date in 2020, and had mild cognitive impairment.

Clinical records documented over a two week period indicated that the resident had sustained multiple falls at the home. The resident incurred injuries from many of the falls and pain was documented in some cases.

The plan of care for resident #003 documented that the resident was to have a number of falls prevention interventions in place, among them the resident was to be reminded to call for assistance and wait before getting up.

Post fall assessment and analysis report for each of the falls were reviewed. The root cause for the majority of the falls identified that the resident was trying to walk without calling for assistance. The assessment stated to encourage the resident to seek for assistance or use the call bell.

Fall Lead Registered Nurse (RN) #115 and Registered Practical Nurse (RPN) #114 stated that resident #003 would not have known to use the call bell. RPN #114 stated that the call bell was not an effective fall prevention intervention if the resident was not able to call for assistance.

Director of Care (DOC) #103 stated that the purpose of the root cause analysis was to assess the reason behind the falls and review the plan of care. The expectation was for the registered staff to either remove something from the plan of care or add something to the plan of care based on the root cause analysis.

DOC #103 acknowledged that interventions were discussed, but not until after the resident sustained a significant injury. The DOC acknowledged that when resident #003 was being reassessed and the plan of care was being revised because care set out in the plan had not been effective, different approaches were not considered in the revision of the plan of care.

The licensee has failed to ensure that when resident #003 was being reassessed and the plan of care was being revised because care set out in the plan had not been effective, that different approaches had been considered in the revision of the plan of care. [s. 6. (11) (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 when any resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, that different approaches have been considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #003's pain was not relieved by initial interventions; the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Clinical record review documented that the resident had chronic and intermittent pain in specified areas of the body.

Resident #003's admission assessment identified that they were having pain.

Shortly after the resident was admitted, Occupational therapist (OT) #116 noted that the resident reported symptoms and increased pain and that they could only maintain a

specified position for a short duration before pain worsened.

OT #116 stated that when they assessed the resident on a specified date in 2020, they had complained of pain.

On a specified date in 2020, Physiotherapist (PT) #113 noted that the resident had chronic pain.The PT noted that the resident would benefit from the therapy program for their pain.

Clinical records indicated that while residing in the home, the resident sustained multiple falls that resulted in pain.

Pain Level Summary was reviewed under the vital signs tab in point click care (PCC) and documented that the resident was experiencing pain.

Medication Administration Record (MAR) were reviewed and it was noted that medications were ordered for pain.

Review of the MAR indicated that the pain medications were not administered to the resident for two consecutive months in 2020 while they were experiencing pain.

Resident Assessment Instrument (RAI) Coordinator #105 and DOC #101 said that the pain assessment should have been completed by the charge nurse upon admission when pain was identified. The assessment was to be completed in the PCC under the assessment tab using the clinically appropriate tool, however, it was not done.

The licensee has failed to ensure that when resident #003’s pain was not relieved by initial interventions; the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

2. The licensee has failed to ensure that when resident #008’s pain was not relieved by initial interventions; the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Resident #008’s progress notes documented that upon admission to the home, the residents’ family had reported to the admission nurse that the resident experiences pain.

In an interview with inspector #532 on July 15, 2020, the resident indicated that they had

pain.

Review of Point of Care (POC) documentation showed that Personal Support Worker (PSW) staff had identified that resident #008 was experiencing pain.

A review of the resident’s assessments showed that a Pain Assessment had not been documented upon admission or at any other time.

RPN #114 stated that PSW staff were to document if a resident was experiencing pain in POC, and report concerns of pain to registered staff. RPN #114 stated that they were not aware that resident #114 was experiencing pain and that PSW staff had not reported concerns related to resident #114 and pain.

DOC#104 stated that registered staff relied on PSW staff to report concerns of resident pain.

DOC #104 also stated that PSW staff who document that a resident was experiencing pain were to immediately report this to registered staff so that registered staff could initiate a pain assessment, review pain medication and its' effectiveness.

DOC #104 acknowledged that PSW staff had identified that resident #008 was experiencing pain over a specified time frame.

DOC #104 stated that if pain had been reported at admission by the family and the PSW staff were documenting pain, then a comprehensive pain assessment should have been completed for the resident to identify and assess the pain.

The licensee failed to ensure that when resident #008’s pain was not relieved by initial interventions; the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (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 when resident #008 or any other resident's pain is not relieved by initial interventions; the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care related to pain based on an interdisciplinary assessment with respect to the resident's health conditions including allergies, pain, risk of falls and other special needs was developed for resident #008.

Resident #008 was admitted to the home on a specified day in 2020. Upon admission to the home, resident #008’s family reported that the resident experienced pain.

Review of POC documentation over a four week period for resident #008 showed that the resident had voiced or exhibited signs of pain. More specifically, it was documented that the resident displayed protective body movements indicating the presence of pain, verbally complained of pain, and displayed facial expressions of pain on multiple occasions.

Review of the resident’s care plan in PCC showed that pain had not been identified as an area of focus, nor were goals or interventions related to pain developed.

DOC #104 acknowledged that there was no plan of care for resident #008 related to the pain.

The licensee failed to ensure that a plan of care related to pain based on an interdisciplinary assessment with respect to the resident's health conditions was developed for resident #008. [s. 26. (3) 10.]

Issued on this 17th day of July, 2020

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

Original report signed by the inspector.