Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Central West District
609 Kumpf Drive, Suite 105
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Original Public Report

Report Issue Date: March 14, 2023	
Inspection Number: 2023-1365-0004	
Inspection Type: Complaint Follow up Critical Incident System	
Licensee: Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as a General Partner	
Long Term Care Home and City: Chartwell Westmount Long Term Care Residence, Kitchener	
Lead Inspector JanetM Evans (659)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 2-3, 6-9 and 14-17, 2023

The following intake(s) were inspected:
- Intake: #00016008 and Intake: #00016390 related to alleged resident neglect and
- Intake: #00018684 - Follow-up related to Duty to Protect

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2022-1365-0003 related to FLTCA, 2021, s. 24 (1) inspected by JanetM Evans (659)

The following **Inspection Protocols** were used during this inspection:

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Continence Care
Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Failure to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee failed to protect a resident from neglect by staff. Specifically, they demonstrated a pattern of inaction that jeopardized the health, safety and well-being of the resident.

The legislation defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents (O. Reg. 246/22 s. 7)

Over a three month period in 2022, a resident was assessed to have a functional decline in their health status.

The home's continence management program said that based on the resident's assessment of continence a resident-focused care plan would be developed to address resident care needs.

In October 2022, a significant change Minimum Data Set (MDS) assessment documented the resident's bowel and bladder continence status to have deteriorated. The resident was further assessed to potentially benefit from a specified toileting protocol based on their voiding pattern, for cognitively impaired residents.

The resident's care plan did not provide direction to staff related to a specified toileting protocol.

Staff were not familiar with the specified toileting protocol for the resident.

The Continence/falls lead and a Co-DOC acknowledged the specified toileting protocol had not been implemented in the resident's plan of care and it should have been. The Continence/falls lead said that the resident often fell when they attempted to self toilet.

On a specified date in December 2022, video surveillance from the resident's room showed that an alarm was sounding and the resident had got out of bed on their own and they were unsteady on their feet. Three minutes later, their alarm was silenced and the resident's door was partially opened; a staff member looked into the room, closed the door and left without responding to the resident. Thirty five minutes later, the resident was laying on the floor and an alarm can be heard. The resident remained on the floor for forty three minutes when a staff member entered the room and found them. The resident had been incontinent. They were assisted back to bed after being assessed to have no injury.

The Co-DOCs stated that the staff member who looked in the room should have stayed with the resident or assisted them to the chair and called for assistance instead of leaving the resident standing alone. If the person who had turned the alarm off had stayed to assist the resident, then the resident may not have fallen. They stated the risk of turning the alarm off and walking away would be the resident would fall and have an injury.

Over a two month period in 2022, the resident had 14 falls. One fall occurred on day shift, the remainder on evenings or night shift. Only one of the falls was documented as witnessed.

Resident Assessment Protocol (RAPS) for falls, from November 2022, stated the resident was not compliant with interventions but the goals and interventions in place were effective for the resident's safety.

Their plan of care for falls was last updated in November 2022, to include a specified device. Following the addition of the specified devices, the resident continued to have unwitnessed falls in their room but no further interventions were implemented to prevent falls. There was no documentation to support that alternative falls interventions had been considered for the resident, given that those in place had not been effective to prevent falls.

The falls lead said sometimes the interventions for falls prevention were successful, but other times by the time staff arrived, the resident was already on the floor.

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In December 2022, a second video surveillance from the resident's room showed they fell from bed. An assessment of the resident post fall documented there was no overt sign of injury to the resident from the fall, yet they had sustained a head injury.

A photo of the resident following this fall showed an area of altered skin integrity to their left forehead area. There was no skin and wound assessment completed for this wound.

The home's procedure for skin and wounds was that registered staff would complete a skin assessment using the Skin-Initial Skin and Wound assessment in PCC with any newly identified alteration in skin integrity.

The resident's plan of care had directions to staff related to specified areas of altered skin integrity but nothing related to the head abrasion.

A PSW said the SDM shared video with them of this fall and they noted the area of altered skin integrity to the resident's head. They did not notify anyone of this as the SDM said the nurse already knew.

A Co-DOC said they thought the resident had an area of altered skin integrity on their head following this fall. A skin and wound assessment should have been completed when it was noted.

An RN had been present in the resident's room following this fall. They stated they had not assessed the resident for a head injury and they did not recall the resident having a wound following this fall. They said the RPN should have assessed the resident.

The home's fall prevention program's purpose was to outline their fall prevention and injury reduction program and to provide direction and guidelines to the Interdisciplinary Team to direct resident care related to fall assessment, prevention, injury reduction, fall intervention and post fall procedures that foster resident independence, autonomy, dignity and quality of life while ensuring safety. The procedure stated that a head injury routine (HIR)/neurological assessment would be initiated for 48 hours in the case of a suspected head injury or unwitnessed fall unless otherwise directed by the attending physician.

Special instructions documented to the resident's PCC profile stated, "Do not initiate HIR, unless Head injury".

The resident's clinical records showed several HIR had been initiated. There was not a HIR noted for each of the 13 unwitnessed falls over the two months. There was only one HIR completed in December

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2022, which had one set of neurovitals and vital signs completed, and the rest of the document was crossed out. There was no HIR noted for the second fall in December 2022, fall when the resident sustained a head injury.

A Co-DOC #101 acknowledged the HIRs were not completed and should have been completed.

An email to the home following the first fall in December 2022, requested more frequent checks of the resident. A critical incident report submitted to the Ministry of Long Term Care in December 2022, stated that 30 minute safety checks had been initiated to prevent further recurrence.

On a specified date in December 2022, the unit planner documented initiation of every (Q) 30 min checks for the resident.

Resident #002's care plan, task records, Kardex and documentation survey record for December 2022, did not show documentation of safety checks every 30 minutes. The Documentation Survey report for December 2022, documented a safety check every shift to ensure the devices in use were functioning.

A 30 minute safety check flow sheet for three days following the second fall in December 2022, was located in the resident's clinical records, however the document was not completed in full.

A Co-DOC said the documentation for 30 min checks should all be in the resident's chart. They acknowledged the 30 minute flow sheet had not been completed in full for every 30 minutes monitoring of the resident.

Despite staff being aware of the resident's continence and fall risk status, and the deterioration of the resident's overall health, they demonstrated a pattern of inaction by not:

- implementing a trial of the recommended toileting protocol to determine if this would assist in less incidents of incontinence and the resident's increased comfort;

- intervening to assist the resident when they were observed standing up in their room and unsteady on their feet;

-completing monitoring of the resident post fall including head injury and,

-completing a skin and wound assessment for a visible alteration in skin integrity.

These actions jeopardized the resident's health, safety and well-being and put them at potential risk for further harm.

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Sources : Observation of video surveillance of inside resident #002's room -supplied by the SDM for dates December 14 and 28, 2022, observation of video surveillance supplied by the home (of hallway) for December 14, 2022, Photo of resident #002 post head injury Dec 28, 2022. Records: Resident #002's plan of care, November 1- December 31, 2022, progress notes, Resident Assessment Protocol (RAPS) for falls, dated November 17, 2022, HIR for resident #002 dated December 14, 2022, Bowel and Bladder Continence assessments dated October 2022, December 2022 Documentation Survey Report. Physician's progress notes; Resident Care and Services meeting, December 15, 2022.
Resident Falls Prevention Program, LTC-CA-WQ-200-07-08 revised June 2022, Head Injury Routine (HIR) LTC-CA-ON-200-07-04, dated January 2023, Continence care and bowel management program, LTC-CA-ON-200-02-05, dated December 2021, Skin and Wound assessments, Skin Care Program Overview LTC-CA-WQ-200-08-01, revised December 2017, Abuse free communities – Prevention, Education and analysis LTC-CA-WQ-100-05-18, revised March 2022, Abuse Allegations and Follow up, LTC-CA-WQ-100-05-02, revised March 2022, MDS – October13, 2022, Urinary Continence management CST, Home's investigation, December 2022 unit planner, 30 minute safety check flow sheets, training records, interview with Co-DOC #101, Co-DOC #100, Programs lead, and staff.

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