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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419, rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 16, 2019	2019_807644_0006	020999-17, 021201-17, 023491-17, 008863-18, 031676-18, 005820-19, 005924-19, 008185-19, 008846-19	Complaint

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 Woodhaven Long Term Care Residence
380 Church Street MARKHAM ON L6B 1E1

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

ANGIEM KING (644), SUSAN SEMEREDY (501)

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): June 11, 12, 13, 14, 17, 18, 19, 20, 21, 24, 25, 26, 27 and 28, 2019.

During this inspection the following complaints were inspected:
-Log #008863-18 related to Prevention of Abuse,
-Log #005924-19 related to Falls Prevention,
-Log #020999-17 related to Sufficient staffing,
-Log #008185-19 related to Sufficient staffing, Continence Care and Bowel Management, Skin and Wound Care,
-Log #008846-19 related to Sufficient staffing, Continence Care and Bowel Management, Personnel Support,
-Log #023491-17 related to Prevention of Abuse.

Follow-up Log #031676-18 related to Nutrition and Hydration.

The following Critical Incident System (CIS) intakes were inspected during this inspection:
-Log #005820-19 related to Falls Prevention and management,
-Log #021201-17 related to Prevention of Abuse.

Inspector Asal Fouladgar #751 in training was on-site during this inspection.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Assistant Directors of Care (ADOC), Business Manager (BM), Regional Director, RAI-Coordinator, Resident Care Coordinators (RCCs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Care Providers (PCP), Physiotherapist (PT), Receptionist, and Substitute Decision Makers (SDM's).

During the course of the inspection, the inspector(s) conducted observations of personal care, staff and resident interactions and the provision of care, record review of health records, staffing schedules, home's investigation records, home's complaint records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care
Sufficient Staffing

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)**

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. 6. (7)	CO #001	2018_486653_0028	501

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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was at least one registered nurse and a member of the regular nursing staff on duty and present at all times.

The Ministry of Health and Long-Term Care (MOHLTC) received a complaint on an identified date, indicating shortage of staff on three-specific shifts where there was no registered nurse (RN) in the building.

Review of the home's Absent call-in sheets, Timecard report sheets and Medication administration audit report sheets from specific months in 2017, and interview with the Director of Care (DOC) #113 revealed three specific registered nurse (RN)'s shifts the RN was not replaced in 2017.

It was indicated on the Timecard report sheet and the Medication administration audit report sheet RN, Resident Care Coordinator (RCC) #105 was in the building on a specific date in August 2017, at a specified time.

In separate interviews, RCC #105 stated when a RN on a specified shift needed to be replaced and no RN was found to fill the shift the RCCs would share responsibilities for coverage of the shift. RCC #105 further stated they did not recall the specific dates when this occurred in 2017. Assistant Director of Care (ADOC) #128 stated they also did not recall the specific dates when they worked as the RN in the building in 2017.

In an interview, DOC #113 stated that on several occasions in 2017 they recalled that ADOC #128 commented about working a specific shift when there was no RN in building. They further stated they did not recall the dates that ADOC #128 worked as an RN in 2017. DOC #113 acknowledged the home failed to ensure that there was at least one registered nurse and a member of the regular nursing staff on duty and present at all times. [s. 8. (3)]

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 there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times,, 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 resident #012, #013, and #014 exhibiting altered skin integrity, had been reassessed at least weekly by a member of registered nursing staff, if clinically indicated.

The MOHLTC received a complaint from resident #012's substitute decision-maker (SDM) related to care concerns. An interview with the SDM indicated they had often found the resident required continence care. The SDM stated resident #012 was getting identified alteration in skin integrity on two specific areas of the body because staff do not

provide specific continence care.

A review of resident #012's current written plan of care on an identified date in June 2019, indicated there was alteration in skin integrity on an identified body part as of April 2019. A review of resident #012's skin assessments indicated the resident had an initial altered skin integrity on specified body part on an identified date in April 2019, and an initial altered skin integrity on a different body part on an identified date in April 2019. A follow up weekly skin assessment to a specified body part was completed on an identified date in April 2019. There were no further weekly follow up skin assessments related to these areas.

In an interview with ADOC #118 on an identified date in June 2019, indicated resident #012 continued to have altered skin integrity and required a specific treatment with every continence care.

A review of the home's wound care treatment policy #LTC-CA-WZ-200-08-03, last revised December 2017, indicated that upon discovery of a skin alteration, staff would initiate a baseline assessment and thereafter, the appropriate assessment would be used for weekly assessments. Each assessment contains clinically relevant information to be used to determine the status of the alteration. According to this policy altered skin integrity includes a specific, identified altered skin integrity.

An interview with RCC #119 and ADOC #118 indicated staff were to do a weekly skin assessment if there was skin alteration and acknowledged that resident #012 had ongoing issues surrounding altered skin integrity on an identified area of the body.

An interview with DOC #113 indicated weekly skin assessments are required for all altered skin integrity including specific types of altered skin integrity. The DOC acknowledged that weekly skin assessments for resident #012 had not been completed for the above noted skin alterations.

2. Resident #013 was inspected for altered skin integrity to increase the sample size related to non-compliance found for resident #012.

An observation conducted on an identified date in June 2019, indicated the resident had altered skin integrity on specified body part.

A review of resident #013's medical record indicated an initial skin alteration was

assessed on an identified date in June 2019, that stated an alteration in skin integrity on an identified body part with specific measurements. A review of the physician's orders indicated in the treatment administration record that registered staff were to monitor daily the identified altered skin integrity and complete a weekly skin assessment on a specific day. A review of skin assessments indicated a weekly skin assessment was not completed on the specific day in June 2019. A review of progress notes indicated there was no assessment for this altered skin integrity up until an identified date in June 2019.

3. Resident #014 was inspected for altered skin integrity to increase the sample size related to non-compliance found for resident #012.

An observation conducted on an identified date in June 2019, indicated the resident had altered skin integrity on specified body part.

A review of resident #014's medical record indicated an initial skin alteration was assessed on an identified date in June 2019, that stated an alteration in skin integrity on an identified body part with specific measurements. A further review of assessments and progress notes indicated this altered skin integrity was not reassessed up until an identified date in June 2019.

An interview with ADOC #118 indicated the home's policy is for a weekly skin assessment to be completed for any altered skin integrity including a specific type of altered skin integrity. The ADOC acknowledged resident #012, #013 and #014's alteration in skin integrity had not been reassessed weekly by a member of registered nursing staff.. [s. 50. (2) (b) (iv)]

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 resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff,, to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the plan of care set out clear directions to staff and others who provide care to the resident.

The MOHLTC received a complaint from resident #012's substitute decision-maker (SDM) related to concerns about the lack of care and staffing. An interview with the complainant indicated the staff who provided care to resident #012 was unaware of their care needs. The SDM stated the resident required continence care and they had often found the resident lacking provision of identified care.

A review of resident #012's current written plan of care indicated the resident with specific continence care. A review of the Minimal Data Set (MDS) assessment dated on an identified date in April 2019, indicated the resident with specific continence care. Under the bladder continence section, the plan indicated that the resident was identified with specific continence care with specific care needs. As well, the plan indicated to provide assessed continent care products by referring to the home's identified product list. A review of the list dated on a specified date in May 2019, found in the supply room indicated resident #012 required a specific continence product at specified intervals.

An observation on a specified date in June 2019, indicated the resident was provided an identified care and there were several identified continence products noted in a specific area with an identified mark.

An interview with Personal Care Provider (PCP) #110 indicated resident #012 required specific continence care. PCP #110 also indicated the resident required a specific

continence product. An interview with PCP #124 indicated resident #012 does not wear a specific continence product as indicated on the identified product list and received a specific continence product that was listed on the resident's specific continence document.

An interview with Registered Practical Nurse (RPN) #111 indicated resident #012 required specific continence care and could not explain why there was an inconsistency with the MDS assessment and written plan of care. An interview with Resident Care Coordinator (RCC) #106 indicated resident #012 had been receiving a special continence product that the Director of Care (DOC) had been recently ordering and acknowledged the list had not been updated to reflect the resident's current continence product.

An interview with RCC #119 and Assistant Director (ADOC) #118 indicated that resident #012's written plan of care was not updated to reflect their current level of continence care . As well, RCC #119 and ADOC #118 acknowledged that the identified product list had not been updated to reflect resident #012's current continence product.

An interview with DOC #113 indicated that they were the one responsible for updating the identified product list and had failed to do so for resident #012. The DOC acknowledged that the written plan of care did not provide clear direction reflecting resident #012's current level of bowel function and type of identified product. [s. 6. (1) (c)]

Issued on this 17th day of July, 2019

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

Original report signed by the inspector.