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
Feb 18, 2020	2020_823653_0005	020516-19	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

ROMELA VILLASPIR (653)

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): January 20, 21, 22, 23, 24, 27, 28, 29, 30, 31, 2020.

Complaint Log #020516-19 related to resident #001's skin and wound care, continence care and bowel management, and hospitalization, had been inspected.

During the course of the inspection, the inspector conducted observations of resident care provision, reviewed the staff schedule, clinical health records, hospital records, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the residents, Substitute Decision-Maker (SDM), Family Members, Personal Care Providers (PCPs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Resident Care Co-ordinator (RCC), Physiotherapist (PT), St. Elizabeth RN, and the Skin Care Co-ordinator (SCC)/ Assistant Director of Care (ADOC).

PLEASE NOTE: A Compliance Order related to s. 6 (7) of the Long-Term Care Homes Act, S.O. 2007, identified in this complaint inspection report #2020_823653_0005 (Log #020516-19) will be issued under concurrent Critical Incident System (CIS) inspection report #2020_823653_0006 (017672-19, 017679-19, 023206-19, 000245-20).

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Hospitalization and Change in Condition
Medication
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 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. (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 that the written plan of care sets out clear directions to staff and others who provided direct care to residents #001 and #004.

The Ministry of Long-Term Care (MLTC) received a complaint related to resident #001's skin and wound care. An interview with the complainant indicated the resident was admitted to the home with an alteration in skin integrity that had gotten worse over time due to lack of care in the home.

A review of resident #001's health records indicated they were admitted in the hospital for 13 days.

A review of progress notes and the prescriber order form indicated on the day resident #001 returned to the home, Registered Nurse (RN) #112 confirmed the treatment orders for their alteration in skin integrity with the physician.

A review of resident #001's electronic Treatment Administration Record (eTAR) did not reflect the treatment orders confirmed with the physician.

During Inspector #653's observation of resident #001's treatment provision, Registered Practical Nurse (RPN) #110 referred to a hard copy of the prescriber order form with the treatment orders confirmed by the physician. The RPN indicated to the inspector that there were unclear treatment orders on the resident's eTAR so they had photocopied the prescriber order form to ensure they had the correct treatment order to refer to.

An interview with the Assistant Director of Care (ADOC) indicated they were made aware of the unclear orders on the resident's eTAR and they had gone through with all of the orders and discontinued the old orders. [s. 6. (1) (c)]

2. Due to the area of non-compliance identified related to Long-Term Care Homes Act (LTCHA) 2007, c. 8, s. 6 (1) (c), the sample size was expanded to two additional residents, which included resident #004.

A review of resident #004's assessment indicated they had an alteration in skin integrity.

A review of resident #004's prescriber order forms indicated the treatments for their alteration in skin integrity.

A review of resident #004's eTAR indicated both the old and new treatments were being signed off by the registered staff as provided.

During an interview, RPN #116 reviewed resident #004's eTAR and acknowledged the two different treatment orders for the alteration in skin integrity signed off by the registered staff as being provided. The RPN further acknowledged the written plan of care did not provide clear directions as two different treatment orders were on the resident's eTAR. RPN #116 further indicated the previous order should have been discontinued. [s. 6. (1) (c)]

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any policy instituted or otherwise put in place was complied with.

According to Ontario Regulation (O. Reg). 79/10 s. 50 (1) (4), The skin and wound care program must, at a minimum, provide for the following: Treatments and interventions, including physiotherapy and nutrition care.

A review of the home's policy titled "Wound Care Treatment" #LTC-CA-WQ-200-08-03 revised in December 2017, indicated that a physician or RN (EC) order is required for wound care involving a stage III or greater pressure ulcer. Enterostomal Therapists (ET) can be consulted for wound care recommendations, however, before the order can be implemented it must be reviewed and approved by a physician. Under procedures and treatment, it is indicated that physician/ nurse practitioner orders are required for pressure ulcers stage III and greater.

The MLTC received a complaint related to resident #001's skin and wound care. An interview with the complainant indicated the resident was admitted to the home with an alteration in skin integrity that had gotten worse over time due to lack of care in the home.

A review of resident #001's clinical health records indicated they were admitted to the home with an alteration in skin integrity.

A review of resident #001's prescriber order forms from four different dates indicated transcribed treatments for their alteration in skin integrity without the physician's signature.

A review of resident #001's eTAR for an identified time period indicated the treatments for the alteration in skin integrity from the four different dates were implemented without the physician's orders.

An interview with the ADOC indicated when they would transcribe the ET recommendations on the prescriber's order form, they would flag it in the chart and let the primary nurse know that there was a new order and to have it seen and sign off by the physician during their rounds. The ADOC and the inspector reviewed the above mentioned documentation and the ADOC acknowledged that the home's policy had not been complied with, as the treatments for resident #001's alteration in skin integrity were not signed off by the physician. [s. 8. (1) (b)]

2. Due to the area of non-compliance identified related to O. Reg. 79/10 s. 8 (1) (b), the sample size was expanded to two additional residents, which included resident #004.

A review of resident #004's assessment indicated they had an alteration in skin integrity.

A review of resident #004's prescriber order forms from three different dates indicated transcribed treatments for their alteration in skin integrity that were not signed off by the physician.

The ADOC and the inspector reviewed the above mentioned documentation and the ADOC acknowledged that the home's policy had not been complied with. [s. 8. (1) (b)]

3. According to O. Reg. 79/10 s. 114 (2), The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

A review of the home's policy titled "Three Month Medication Review (3MMR)" #LTC-CA-WQ-200-06-21 revised in December 2017, indicated the following under procedures:

1. In preparation for a quarterly 3 Month Medication Review, the Registered Staff upon receipt of the 3 Month Medication Review from the pharmacy will:
a. Review the medications the resident is taking as per the current MAR sheet;
b. Reviewing the PRN medications ordered including frequency of use;
c. Sign the first check indicating the first review has been completed;

d. A second check will be completed by a second (and different) Registered Staff; comparing the current MAR/ physician orders with the 3MMR;
e. Once completed the second Registered Staff will sign the 3MMR and forward the prepared forms to the physician/ nurse practitioner to consider the ongoing need for PRN medications, if there has not been recent use the physician is to consider discontinuing the medication.

2. Once the physician/nurse practitioner has reviewed and signed the 3MMR Registered Staff will review the 3MMR and if there are new orders will process the 3MMR following the procedure for processing physician orders.

3. If there are any discrepancies or unclear areas, Registered Staff will contact the physician/nurse practitioner for clarification.

4. Once signed and processed the 3MMR will be filed in the resident chart in the physician order section.

During an observation of resident #001’s treatment provision, RPN #110 and the inspector noted two bottles of medication in the first drawer of the resident’s dresser by their bedside.

An interview with RPN #110 indicated they had asked the Substitute Decision-Maker (SDM) a day prior, to take home the two bottles.

A review of a late entry progress note indicated RPN #110 had found the two bottles of medication in the resident’s room, and reinforced to the SDM to take them home.

A review of resident #001’s prescriber order forms indicated the order for the medication the RPN and inspector found, was confirmed on admission, and signed off by the physician. However, the identified medication was not noted on the succeeding three month medication reviews and prescriber order forms. A review of resident #001’s electronic Medication Administration Record (eMAR) for a period of six months, indicated the identified medication had been administered to the resident.

An interview with RPN #110 and the Resident Care Coordinator (RCC), indicated the identified medication was missed on the three month medication reviews. The RCC further acknowledged if the registered staff had checked the eMAR properly against the three month medication review document as required by the home’s policy, then the

order for the medication would not have been missed. The RPN and the RCC acknowledged that the home's policy was not complied with. [s. 8. (1) (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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with, to be implemented voluntarily.

WN #3: 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 the resident exhibiting altered skin integrity received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

The MLTC received a complaint related to resident #001’s skin and wound care. An interview with the complainant indicated the resident was admitted to the home with an alteration in skin integrity that had gotten worse over time due to lack of care in the home.

A review of resident #001's assessment on an identified date, indicated they had an alteration in skin integrity in three different areas.

During an interview, RPN #108 stated that the two alterations in skin integrity were first noted when the resident came back from the hospital on an identified date.

A review of resident #001’s PCC census records indicated they were admitted in the hospital for 12 days.

A review of resident #001’s initial assessment upon re-admission to the home, indicated they still had the existing alteration in skin integrity and the two new areas.

A review of resident #001’s PCC progress note that was created eight days post re-admission to the home, and an interview with Registered Nurse (RN) #115 indicated in addition to the existing alteration in skin integrity, the RN noted two new areas.

A review of resident #001’s prescriber order forms and eTARs did not indicate that a treatment was initiated for the two new areas of altered skin integrity after it had been identified by the registered staff.

An interview with the ADOC indicated they were away on vacation around the time period the resident sustained the new areas of altered skin integrity. The ADOC further indicated that treatment should have been initiated once they were assessed by the wound care nurse. The registered staff were also to initiate an intervention if they had identified the alteration in skin integrity. [s. 50. (2) (b) (ii)]

2. The licensee has failed to ensure that the resident exhibiting an alteration in skin integrity had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated

A review of resident #001's assessment on an identified date, indicated they had an alteration in skin integrity in three different areas.

During an interview, RPN #108 stated that the two alterations in skin integrity were first noted when the resident came back from the hospital on an identified date.

A review of resident #001's PCC census records indicated they were admitted in the hospital for 12 days.

A review of resident #001's initial assessment upon re-admission to the home, indicated they still had the existing alteration in skin integrity and the two new areas.

A review of resident #001's PCC progress note that was created eight days post re-admission to the home, and an interview with RN #115 indicated in addition to the existing alteration in skin integrity, the RN noted two new areas.

A review of resident #001's weekly assessments between a 16 day period following re-admission to the home, did not identify the weekly assessments captured their two additional alteration in skin integrity.

An interview with the ADOC indicated the home's expectation was for a weekly assessment to be completed for the alteration in skin integrity after it had been identified. [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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required and is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

During an observation of resident #001's treatment provision, RPN #110 and the inspector noted two bottles of medication in the first drawer of the resident's dresser by their bedside.

An interview with RPN #110 indicated they had always kept the identified medication in their medication cart, however, the day prior, the RPN had given the two bottles to the SDM to take home. RPN #110 was not aware they were left in the resident's dresser by their bedside. The RPN further indicated all drugs were supposed to be stored in the medication cart.

During an observation of residents in an identified home area, the inspector noted a red basket container that had residents' topical medications, placed in the nursing desk at the nursing station. The nursing station door was unlocked, and the inspector was able to push the door open and entered the nursing station.

An interview with evening RPN #127 indicated they had the red basket container of topical medications out in the nursing station, because some of the residents just had their shower and had to have the medications applied. The RPN stated the topical medications were supposed to be in the treatment cart in the locked medication room.

An interview with the ADOC acknowledged the above mentioned information and indicated that the home's expectation was for drugs to be kept in the medication room, and prescribed topical creams locked in the treatment cart. [s. 129. (1) (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 drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

Issued on this 26th day of February, 2020

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

Original report signed by the inspector.