Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection 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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 29, 2017	2017_591623_0005	007597-17, 007782-17	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 Wynfield Long Term Care Residence
451 Woodmount Drive OSHAWA ON L1G 8E3

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

SARAH GILLIS (623)

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): April 27, 28, 2017 onsite May 2, 3, and 5, 2017 offsite.

The following logs were inspected concurrently during this complaint inspection;
Log#007782-17 complaint related to a fall in the home.
Log#007597-17 Critical Incident Report related to an incident with injury resulting in transfer to hospital and change in condition.

During the course of the inspection, the inspector(s) spoke with the Substitute Decision Maker (SDM), Director of Care (DOC), Associate Director of Care (ADOC), RAI Coordinator (RAI), Registered Nurses (RN), Personal Care Providers (PCP).

In addition, during the course of this inspection, the inspector toured the home, reviewed clinical health records, the licensee's investigation documentation, staffing compliments, call bell records, falls prevention committee meeting minutes, and the homes related policy; LTC-CA-WQ-200-07-08 - Resident Falls, LTC-CA-WQ-200-07-19 - Physical Restraint.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **1 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	Legendé 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan related to falls prevention interventions.

A critical incident report (CIR) was submitted to the Director for an incident that occurred on a specific date and time. The CIR indicated that the resident was taken to the hospital and which resulted in a significant change in the resident's health status. The CIR indicated the following description of the incident; On a specific date and time resident #001 was found on the floor of the common bathroom by co-resident #002. Resident #001 was immediately transferred to hospital for assessment.

A review of the clinical records for Resident #001 indicated the following;
Resident #001 has a history of multiple falls over three years and was assessed as a high risk for falls. Resident #001 was followed by the falls prevention committee, occupational therapy and physiotherapy for falls prevention and interventions.

A review of the licensee's internal investigation including a written statement from RN #103 related to the CIR indicated the following information;
Resident #001 was last observed by RN #103 on a specific date and time, sitting in a wheel chair in the TV lounge with personal alarm on. RN #103 was notified 15 minutes later by resident #002, that resident #001 was on the floor and needed help. When RN #103 arrived at the common bathroom resident #001 was lying face down on the floor, the wheel chair was beside, the personal alarm was not sounding. As a result resident #001 was transferred to the hospital for assessment. Following the transfer to hospital RN #103 checked the personal alarm and found that it was in working order.

Review of the plan of care that was in place at time of the incident indicated the following;

Falls: High Risk for Falls. Resident #001 will not call for staff assistance. Staff to keep a close and frequent watch over through day and night. Wireless personal alarm to be in place.
Goal: Resident #001 will have decreased number of falls and injuries over 3 months.
Interventions: Resident #001 is a two person transfer. Resident #001 will attempt to self transfer in the toilet numerous times throughout the day and night, therefore keep resident situated close to information centre for monitoring during the day and evening. Personal alarm in place while in the chair and in bed.
- resident #001 to use wheel chair x 2 person assist and ceiling lift when needed, resident is able to self propel the wheelchair.
- Physiotherapy: strengthening and balance.
- Ensure appropriate safety device is in use. Resident #001 has a wireless personal alarm to alert staff of resident ambulating/transferring out of recliner, wheelchair. This is worn at all times when up.

- When in bed resident uses a wireless alarm that also rings into the nursing call system, bed is in lowest position, call bell attached to resident. Scheduled toileting plan. Remind resident #001 to call for staff help.
- leave bathroom light on at night.
- staff to constantly remind resident #001 to call for assistance and wait before getting up.

Review of the progress notes from a specific date to a specific date indicated the following:

On a specific date and time - Resident #001 has a temporary personal alarm in place to be used when up in wheel chair.

On a specific date and time - follow up to previous note - resident #001 to use wireless alarm when in bed.

During an interview on April 28, 2017, PCP #105 indicated that on the date of the incident resident #001 had a different chair alarm on, one that clothes pinned to the resident and not the wireless sensor pad. The sensor pad wireless alarm had to be taken off because the alarm was malfunctioning and could not be turned off. Resident #001 was able to remove the new chair alarm with the clothes pin clip but that was the only option available. Resident #001 could not be without an alarm. PCP #105 indicated that there was no additional monitoring put into place when resident #001 did not have the wireless alarm to use.

During a telephone interview on May 2, 2017, RN #103 indicated that on the date of the incident the chair alarm for resident #001 needed to be changed because it was not working properly. RAI Coordinator #108 changed the alarm from the wireless one that resident was supposed to use, to one that will alarm and talk to the resident saying "sit down". The new alarm was not wireless, it connected to the residents clothing with a clip. When the resident tries to stand up and the string is pulled then the alarm will go off. RN #103 indicated that this clip was easily removed and that resident #001 could undo it. RN #103 indicated that at the time of the incident when resident #001 was discovered on the bathroom floor, the personal alarm was not sounding at the time.

During an interview May 5, 2017, RAI #108 indicated that he/she is responsible for the chair/bed alarm program. RAI #108 indicated that resident #001's care plan in point click care (PCC) indicated that he/she was to have a chair pad wireless personal alarm in

place for the wheel chair and a wireless personal alarm on the bed. On the date of the incident, resident #001 required a replacement chair alarm that day. RAI #108 confirmed that on a specific date the wireless personal alarm for resident #001 was not working correctly and was replaced by a temporary chair alarm that was attached to the resident's clothing using a clip. This alarm both talks to the resident and has an audible alarm. The alarm will activate if the resident pulls the string. RAI #108 confirmed that it would be possible for resident #001 to un-clip that type of alarm if they wanted to, which would then allow the resident to stand without the alarm sounding. RAI #108 indicated that there were no wireless alarms available in the home, and staff knew that resident#001 could not be left without an alarm.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident #001 as specified in the plan related to falls prevention intervention, specifically the use of the wireless personal alarm. [s. 6. (7)]

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 ensuring that the care set out in the plan of care is provided to the resident as specified in the plan,, to be implemented voluntarily.

Issued on this 29th day of May, 2017

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

Original report signed by the inspector.