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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 26, 2014	2014_225126_0030	O-001014-14	Resident Quality Inspection

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

Long-Term Care Home/Foyer de soins de longue durée

CHATEAU GARDENS LANCASTER LONG TERM CARE CENTRE
105 MILITARY ROAD NORTH, P.O. BOX 429, LANCASTER, ON, K0C-1N0

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

LINDA HARKINS (126), ANGELE ALBERT-RITCHIE (545), MELANIE SARRAZIN (592)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 10, 12-14, 2015 and November 17-21, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care/RAI Coordinator/Environmental Manager, the Activity Coordinator, several registered nursing staff, several personal home support workers, one maintenance staff, the Resident Council President, the Family Council Resident, several residents and several family members.

During the course of the inspection, the inspector(s) reviewed several health care records, reviewed several policies: Skin and Wound (LTCE-CNS-I-3) Wound Care Protocol,Palliative, Pain and Symptom Control (LTCE-CNS-E-4), the pain flow sheet, the housekeeping routine and the Resident's and Family's Councils minutes

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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 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 comply with O.Reg 79/10 s. 8 (1) (b) in that the home did not ensure that the any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

As per O.Reg 79/10 s. 48 (1) 2, every licensee of a long-term care home shall ensure that the following interdisciplinary program is developed and implemented in the home: Skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

The Home's Skin and Wound Policy # LTCE-CNS-I-3(revised April 2014) was reviewed by Inspector #126 and the following requirements were documented:

Policy: "Resident with altered skin integrity and current wound care will have their pain assessed weekly with weekly wound care reassessment.

An Ont-Skin and Wound Assessment will be initiated when there is an alteration in a resident's skin integrity. This record is to be completed weekly by the Registered Staff and is used to document specific information regarding pressure sores and wounds as well as the treatment and healing of the affected areas."

Procedure: " Registered staff will assess, treat and document all areas of altered skin integrity in keeping with the following guideline: 1. Assessment-When documenting an assessment of skin breakdown you need to include the following data: date of observation; stage; site; size-in centimetres (CM) including the length, width and depth; shape, appearance-is there eschar or slough, type and amount of drainage or exudate; odour, inflammation; undermining or tunelling (if present); condition of surrounding skin."

Resident # 008 sustained a lower leg skin tear/laceration on a specific date in October 2014. Since the injury the dressing was changed regularly as per the physician orders. In November 2014, Resident # 008 still requires to have the dressing done as per the physician orders as the left lower leg wound has not healed.

Discussion held with Registered Nurse Staff # 113 on November 20, 2014. She indicated that she removed the dressing that morning in the presence of the physician. S# 113 indicated to Inspector # 126 that the home follows the "Wound Care Protocol-Standing Orders" for dressing change and the Skin Care Coordinator applied the new

dressing as per the physician order that day.

Discussion held with Skin Care Coordinator S # 103 on November 20, 2014. She indicated that Resident # 008 has a category 3 skin tear. S# 103 indicated that as the Skin Care Coordinator role, she is responsible for changing the dressing, completing the weekly skin assessment and the documentation related to skin and wound. S# 103 indicated to Inspector # 126 that the dressing changes are documented in the progress notes and that the home is not using the e- Treatment Administration Record (TAR) at this time. S# 103 indicated that the home was following the "Wound Care Protocol-Standing Orders" as the Skin and wound care program.

S#103 and S#113 were not aware of the home Skin and Wound Policy.

Physician orders were reviewed and it was noted that the physician was ordering treatment for an ulcer not for skin tear/ as identified by the Skin Care Coordinator and Director of Care.

Inspector # 126 reviewed the weekly Skin and Wound Assessment done on Resident # 008 since the injury on October 9, 2014. The weekly Skin and Wound Assessments were done 5 times over the period of 7 weeks.

Inspector # 126 reviewed the progress notes for a specific period in October and November 2014. It was documented in the progress notes that Resident # 008 dressing was changed as per physician orders. The documentation included in the progress notes was " Treatment to LT leg-Left leg ulcer-use bridine and NACL 1:1 wet to dry BID" with no documentation of the assessment of the wound.

The weekly skin assessment are not completed and the documentation of the assessment of the wound is not documented as per the home's Skin and Wound Policy requirements. [s. 8. (1) (a),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 the skin and wound care policy is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 15 (2) (c) in that the licensee did not ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

During an interview with Resident #002 on November 18, 2014, indicated that he/she hit his/her leg coming in or out of the bed, and resulted in a tear and bruise. Upon observation of resident's bed and bed rail Inspector #545 observed sharp edges on one of the three metal tubes of the quarter bed rail installed at the head of the bed. Two of the metal tubes were covered with a plastic cover while a third metal tube did not have a plastic cover, thus exposing metal sharp edges at the level of resident's bed.

Upon review of Resident #002's health record, a progress note on a specific date in November 2014 describing the injury to the leg and that the nurse cleansed the area and covered it.

During an interview with PSW #S102 on November 18, 2014, she indicated she was

aware of Resident's injury and that she had given Resident # 002 a shower and aware of origin of injuries.

During an interview with RPN #S103 and the Director of Care on November 18, 2014 they indicated they were not aware of the missing plastic cover, and would have the quarter bed rail replaced or repaired immediately to ensure that Resident #002 had a safe bed rail for use during transfers in and out of bed. [s. 15. (2) (c)]

2. The source of heat for each of the resident rooms is a single eight foot light brown electric baseboard heater which is located under the window in the resident room.

On November 10th, 2014, while completing the home tour as part of the Resident Quality Inspection, Inspector #592 observed that the electric baseboard heater in the south Hallway television room and the dining room were covered from one end to the other with scrapes, chipped paint enamel and rust.

On November 19th, 2014, in several rooms, it was observed by Inspector #592 that the electric baseboards heater were in the same state of disrepair as in the dining room and south hallway television room.

On November 19th, 2014, 8/15 bedroom doors on east Hallway were observed with scrapes and chipped paint exposing old green paint at the bottom of each door.

- In a specific bedroom , it was observed that the bedroom door was scrapes with chipped paint exposing old green paint at the bottom of the door and the bottom of the door panel was unglued and fixed with grey duct tape covering a part of the damage door in a L shape.

-In another bedroom, it was observed that the wall of the bathroom was observed having scrapes and chipped paint exposing dry wall.

- In three specific bedrooms, it was observed that the bathroom door frame of room were having chipped paint exposing metal.

On November 19th, 2014, one and a half tile were observed missing from around the toilet in a specific bedroom and was exposing brown matter. In another bedroom, one and a half tile was missing and was exposing rust and cement.

-It was observed that half of two floor tiles were missing and three floor tiles were cracked in the East Hallway before exit doors leading outside of the building, exposing black matter and debris. The three floor tiles cracked with three holes and containing dry leaves and cement particles.

- In three specific bedrooms, it was observed that the bathroom door had paint chipped exposing old green paint and wood.

During an interview with Maintenance staff, he indicated to inspector #592 that the bedroom and bathroom doors need to be repaired on an ongoing basis. He indicated to Inspector #592 that he does not have a list of the rooms and bathrooms that are in disrepair. Inspector #592 showed the maintenance department staff the missing floor tiles, which he indicated he was aware of and took notes of the other identified issues.

During an interview with the Administrator and the DOC/RAI Coordinator/Environmental Manager, the Administrator indicated an audit was completed two weeks ago throughout the home,was aware of the damages and indicated that the home was in the process of developing a plan to address the daily safety and repairs of the home. [s. 15. (2) (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 the home furnishing and equipment such as bed rails, walls and flooring throughoutt the home are maintained in a safe condition and in good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odors.

On November 10, 12, 13, 2014, lingering odors were identified by Inspector #592, #126 and #545 in three specific bathrooms at different time of the day.

On November 18, 2014, lingering odor remains for all identified areas.

On November 18, 2014, housekeeping staff# 100, indicated to Inspector #592 that the resident's bathrooms were done on a daily basis and was aware of the lingering odors in all identified areas. S# 100 indicated that urine is in the floor and it did not matter how frequently the bathroom floors were washed and disinfected with the specific identified product's, the lingering odor still remains. S# 100 indicated that air fresheners are located in those bathrooms to address the odor but lingering odor still persist.

Staff # 100 indicated to inspector #592 that the environmental department was aware of the situation and that the home is planning to change flooring.

The DOC/RAI Coordinator/Environmental Manager, indicated to Inspector #592 that she was aware of bathrooms with lingering odors and that the home is waiting for quotes to replace the flooring but in the meantime a citrus disc is being trialed in these bathrooms that are flagged has having lingering odors. She indicated to Inspector #592 that the home does not have any policy and procedures developed and implemented for addressing lingering offensive odors other than to add air fresheners to designated area with lingering odors.

As such the home did not ensure that procedures are developed and implemented for addressing incidents of lingering offensive odors [s. 87. (2) (d)]

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 procedures are developed and implemented for addressing incidents of lingering odors, to be implemented voluntarily.

WN #4: 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:
17. Drugs and treatments. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 26 (3) 17 in that the licensee did not ensure that the plan of care based on an interdisciplinary assessment with respect to the resident's drugs and treatments.

During an interview with Resident #004 on November 12, 2014, indicated having pain and was not taking any medications for this discomfort.

Upon review of Resident #004's most recent plan of care, it was indicated that staff were expected to monitor and report any increased lethargy and breathing rate, cyanosis, left sided heart/chest pain, ascites, or swelling of extremities, left arm weakness. A review of Resident's medication administration record indicated that a pain medication was administered every 72 hours.

During an interview with RN #S113, she indicated she was not aware that Resident #004 was ordered that specific pain medication and was unsure why the resident required this narcotic. Upon review of Resident #004's health record, RN #S113 indicated that the pain medication was ordered on a specific day in April 2014, but was unable to find an assessment in the resident plan of care in respect to resident's drugs and treatments related to this medication.

During an interview with RPN #114, she indicated that she administered medications and treatments to 60 residents and did not have time to complete a pain assessment for all residents. She indicated that evening staff administered the pain medication manage chronic pain but was unsure of type and location of pain; added that the pain medication was ordered in June 2012. The RPN indicated that the pain medication might have been prescribed because Resident #004 was non-compliant with other analgesics.

On November 21, 2014, during an interview with the Director of Care, she indicated that Resident #004 was prescribed that pain medication in June 2012, and dosage increased on a specific day in April 2014, but was unable to explain type, location of pain. The DOC added that the plan of care was not based on an interdisciplinary assessment with respect to Resident #004's prescription of that specific pain medication. The DOC indicated that a pain assessment, including a pain flow sheet should have been initiated to assess Resident's pain, as well as the most recent care plan. [s. 26. (3) 17.]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 60 (2) in that the licensee did not respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

The Family Council minutes were reviewed for the period a period of one year between November 13, 2013 and November 12, 2014 and the following concerns/recommendations were documented such as:
• Family members finding it an inconvenience to reheat food in the microwave located by the laundry room as the microwave in the dining room was removed
• Inability to use reheated bean bags for Residents as no microwave available for this purpose, medication changes not being communicated to family members involved in resident's care
• Availability for the Non-Emergency transportation for residents continued problem
• A request was made to keep the New Palliative Care room locked when not in used to prevent unauthorized access and/or theft and to safeguard from residents that may be wandering

During an interview with the Chairperson of the Family Council on November 19, 2014 she indicated that the licensee did not respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

During an interview with the Administrator on November 19, 2014, she reviewed the previous Administrator's Family Council binder and indicated that she could not provide documentation showing that the licensee responded in writing within 10 days of receiving Family Council advice related to concerns or recommendations. On November 20, 2014, the Director of Care confirmed that the licensee had not responded in writing within 10 days of receiving Family Council advice related to concerns or recommendations. [s. 60. (2)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 85 (4) in that the licensee did not document and make available to the Family Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

During an interview with the Chairperson of the Family Council on November 19, 2014 she indicated that the licensee did not make available to the Family Council the results of the 2013 satisfaction survey for in order to seek the advice of the Council about the survey. She indicated that the 2014 satisfaction survey was done in August 2014, and that the results were still pending.

On November 21, 2014, during an interview with the Activity Coordinator who was assigned as assistant to the Family Council, she indicated that the satisfaction survey was delivered to Residents and families in August 2014 and that the results were not in yet.

She indicated that in 2013, the Administrator did not make the results of the satisfaction survey available to the Family Council in order to seek their advice about the survey. [s. 85. (4) (a)]

Issued on this 10th day of December, 2014

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