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
Jan 9, 2020	2019_818502_0031	020028-19, 020663-19, 022645-19, 023079-19, 023484-19	Critical Incident System

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

Chartwell Lancaster Long Term Care Residence
105 Military Road North P.O. Box 429 LANCASTER ON K0C 1N0

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

JULIENNE NGONLOGA (502)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 18, 19, 20 and 23, 2019.

The following inspections were conducted:
- Log #020028-19 a complaints related to multiple care areas.
- Log #020663-19 a critical incident system report (CIS) #2680-000014-19 related to an incident of alleged resident to resident abuse.
- Log #023079-19 a CIS #2680-000017-19 related to an injury of unknown cause.
- Log #023484-19 a CIS #2680-000016-19 and #022645-19 a CIS #2680-000019-19 related to an incident of alleged staff to resident neglect.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents' Substitute Decision Maker (SDM).

During the course of the inspection, the inspector reviewed several resident's health care records, observed staff and resident interactions, and reviewed licensee's investigation reports.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Hospitalization and Change in Condition
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 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	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 O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #004's pain was not relieved by initial interventions; the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A Critical incident system report (CIS) was received by the Ministry of Long-Term Care (MLTC) related to injury of unknown cause.

Review of resident #004’s progress notes indicated the following:
- on an identified date, a PSW reported that resident #004 was in a lot of pain. The RN noted specified symptoms, they notified the attending physician, who ordered X-ray for the identified area and was completed in hospital. The X-ray and computerized tomography (CT) scan results were negative, and the blood work result was within normal range.

- the next day, resident #004 had a fall and complained of a lot of pain.

- Eleven days later, resident #004 was noted to have a lot of pain during transfer and repositioning on the area identified above. The area was still very sore and tender. The resident had a scheduled identified medication three times a day for more than a year.

Review of the pain assessment record did not identify a completed pain assessment at the onset of the pain or when the resident returned with negative X-ray and CT scan results, however staff continue to document that resident was in a lot of pain and had discomfort on three occasions.

In an interview, RPN #108 indicated that the resident had ongoing pain during transfer and had a scheduled identified medication three times a day. The RPN acknowledged that a pain assessment should have been completed when the pain persists during transfer.

In an interview, RN #107 indicated that staff should have completed a pain assessment on onset of the pain and eleven days after, because the resident was in a lot of pain.

In an interview, the Administrator acknowledged that the registered staff should have completed a pain assessment, due to the resident ongoing pain. [s. 52. (2)]

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 when resident #004's pain was not relieved by initial interventions; the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #2: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's SDM has been provided the opportunity to participate fully in the development and implementation of the plan of care.

Two Critical incident system reports (CIS) and a complaint were received by the Ministry of Long-Term Care related to an alleged staff to resident neglect.

Review of the CIS and the complaint indicated that staff have been putting resident #001 in bed with a continence care product, instead of dressing them with an identified sleepwear provided by the family, which resulted in resident #001 developing a specified disease.

Review of the home's complaint record indicated that the resident's SDM brought to home's attention that they found resident #001 in bed with continence care product only on an identified date and the home had initiated an investigation.

Review of resident #001's written plan of care indicated that the resident displays

specified behaviour during care.

In an interview, PSW #101 indicated that they were assigned to resident #001 the day of the incident. The PSW stated that they put the resident in bed with continence care product without the sleepwear identified above and assumed it was acceptable as they were told so during their orientation.

In an interview, RN #107 indicated that resident #001 was incontinent every night and required to be changed two to three times per night. The routine was to dress the resident in a sleepwear provided by the family. A year prior to this inspection, the resident start displaying specified behaviour each time they were incontinent, and staff attempted to change them. As a result, staff started dressing the resident with a specified sleepwear to reduce the risk of the resident specified behaviour. The specified sleepwear became unsafe for the resident. Then the decision was made and communicated to staff during shift change, to dress the resident as identified in the complaint above and cover them with an extra blanket. RN #107 stated that they SDM was not informed.

In an interview, the Administrator stated that resident #001's SDM wanted the resident to be dressed in a specified sleepwear, but the home decided to dress the resident as described in the complaint for bed time due to their identified responsive behaviour toward staff during care. The Administrator acknowledged that they did not discuss with the SDM. [s. 6. (5)]

Issued on this 13th day of January, 2020

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

Original report signed by the inspector.