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 # / No de registre	Type of Inspection / Genre d'inspection
Jan 29, 2018	2018_704682_0002	000058-18	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

Chartwell Niagara Long Term Care Residence
120 WELLINGTON STREET P.O. BOX 985 NIAGARA-ON-THE-LAKE ON L0S 1J0

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

AILEEN GRABA (682), GILLIAN HUNTER (130), LISA BOS (683)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 11, 12, 15, 16, 17, 18, 22, 23 and 24, 2018.

The following onsite inquiries were conducted concurrently with this RQI: 000595-17 related to reporting and complaints, 019291-16 related to duty to protect from abuse, 024195-17 related to sufficient staffing, personal support services, 024798-17 related to duty to protect from abuse, responsive behaviors, 025853-17 related to plan of care, responsive behaviors, 021011-17 related to reporting and complaints, duty to protect from abuse.

The following critical incident inspections were conducted concurrently with this RQI: 032890-16 related to duty to protect from abuse, 025387-16 related to duty to protect from abuse , 032905-16 related to medication, 033333-16 related to medication, 000566-17 related to medication, 035234-16 related to medication, 033592-16 related to falls prevention, 008270-17 related to falls prevention, 005740-17 related to improper transfers and positioning.

The following complaint inspections were conducted concurrently with this RQI: 033731-16 related to medication, 002349-17 related to duty to protect from abuse, nutrition, plan of care, 022069-17 related to sufficient staffing, availability of supplies, personal support services.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Dietitian (RD), Food Services Manager, registered staff, personal support workers (PSW), housekeeping staff, residents, families and the President of the Residents' Council.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council

During the course of this inspection, Non-Compliances were issued.

- **5 WN(s)**
- **2 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 O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that the residents with the following weight changes were assessed
using an interdisciplinary approach, and that actions were taken and outcomes were evaluated:
1. A change of 5 per cent of body weight, or more, over one month,
2. A change of 7.5 per cent of body weight, or more, over three months,
3. A change of 10 per cent of body weight, or more, over 6 months,
4. Any other weight change that compromises their health status.

A) The plan of care for resident # 091, last revised on an identified date in 2017, revealed they were assessed at moderate nutritional risk and required dietary intervention. The home's Weight and Vital Summary Report, revealed staff had established a goal weight range (GWR) for the resident. On an identified date in 2017, the resident had a recorded weight. They had a recorded weight loss by an identified date in 2018.
An interview held with staff on an identified date in 2018, confirmed that the resident had progressive weight loss over a specified time period between an identified date in 2017 and an identified date in 2018, and that no action had been taken to re-establish the resident's weight within their GWR. Resident #091's weight changes were not assessed using an interdisciplinary approach, and actions were not always taken and outcomes evaluated when the resident experienced undesired weight loss. (Inspector #130).

B) The plan of care for resident #038, last revised on an identified date in 2016, revealed they were assessed at moderate nutritional risk and required dietary intervention.
The home's Weight and Vital Summary Report, revealed that staff had established a goal weight range (GWR) for the resident in kilograms (kg). On an identified date in 2017, the resident had a recorded weight.They had a subsequent recorded weight on an identified date in 2017, which indicated an increase from the previous weight recorded earlier. The resident's weight on an identified subsequent date in 2017, indicated a decrease from the previously recorded weight. Ten months later, the resident's current weight indicated the resident's weight remained below the bottom range of their established GWR.
An interview held with the RD on an identified date in January, 2018, confirmed that the resident's weight had been assessed for the identified date in 2017 increase; however, there had been no assessment after the decrease in weight. Resident #038's weight changes were not always assessed using an interdisciplinary approach, and actions were not taken and outcomes evaluated. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.] (130)

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 residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated.
1. A change of 5 per cent of body weight, or more, over one month, 2. A change of 7.5 per cent of body weight, or more, over three months, 3. A change of 10 per cent of body weight, or more, over 6 months, 4. Any other weight change that compromises their health status, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) The plan of care for resident #095, revealed they had a physician's order for a medication that read: Administer medication for an identified condition. According to the electronic medication administration record (EMAR), a medication was to be administered on an identified time on an identified date in 2017. Staff #511 initialed the EMAR on a identified date in 2017 at an identified time to confirm its administration. A progress note recorded by Staff #512 on an identified date in 2017 at an identified time revealed the medication was not in place. The DOC confirmed in an interview on an identified date in 2018, that for an undetermined period of time between identified dates in 2017, resident #095 did not receive their medication as prescribed by the physician.

B) The plan of care for resident #127, revealed they had a physician's order for a medication that read: Administer medication for an identified condition. According to the EMAR staff #512 administered a medication at an identified time on a identified date in 2016. A progress note recorded by Staff #512 on an identified date in 2016, revealed the medication was not in place. The DOC confirmed in an interview on January 24, 2018, that for an undetermined period of time between an identified date in 2016, resident #512 did not receive their medication as prescribed by the physician. [s. 131.] (130)

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 administered to residents in accordance with the directions for use specified by the prescriber, 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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident and the goals the care was intended to achieve.

A) A comprehensive pain assessment completed for resident #091 on an identified date in 2017, identified the resident had pain. On an identified date in 2017, the resident was prescribed a medication to be administered. On an identified date in 2018, staff #506 confirmed the resident's health status had declined and that pain was a current problem. They also confirmed that there was no written pain focused plan developed that set out the planned care for the resident and the goals the care was intended to achieve, with respect to pain management. [s. 6. (1) (a)] (130)

2. The licensee failed 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.

A) A clinical record review revealed that resident #091 was identified as a high risk for falls and had fall intervention strategies in place. Observations of resident #091 on an identified date in 2018 included a fall prevention strategy logo posted above the resident's bed. During an interview on an identified date in 2018, staff #510 acknowledged that resident #091 did not use that fall prevention strategy. Staff #501 also

acknowledged that the resident no longer used that fall prevention strategy and that it was not included in their current care plan. Staff #501 indicated that the logo should have been removed from the resident's bedside. Staff #501 acknowledged that the home failed to ensure that the written plan of care for resident #091 set out clear direction to staff and others who provided direct care to the resident. [s. 6. (1) (c)] (682)

3. The licensee failed to ensure that when a resident was reassessed and the plan of care reviewed and revised, that different approaches were considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

A) Resident #038 was assessed at moderate nutritional risk that required dietary interventions. The plan of care developed by nursing staff revealed the resident had a Cognitive Performance Scale (CPS) score that indicated cognitive impairment and required assistance with the task of eating. The home's weight and Vital summary report revealed the resident's RD established a GWR; however, recorded weights reviewed from an identified date in 2017 through to an identified date in 2018, revealed the resident's weights were consistently recorded below the GWR throughout this time period. The RD confirmed in an interview on an identified date in 2018, that the resident's weight was below the established GWR. The RD also confirmed that despite nutritional assessments which were completed during the period of weight loss, the plan of care was not revised to include an interventions related to the resident's nutritional status, weight and any risks associated with nutritional care. (Inspector #130).

B) Resident #091 was assessed at moderate nutritional risk with dietary interventions. The plan of care developed by nursing staff revealed the resident had a (CPS) indicating cognitive impairment and required total assistance with the task of eating. The home's Weight and Vital Summary report revealed the resident's RD established a GWR; however, recorded weights reviewed from an identified date in 2017 through to an identified date in 2018, revealed a progressive weight loss and recorded weights that were consistently below the GWR during this time period. The RD confirmed in an interview on an identified date in 2018, that the resident's weight was below the established GWR. The RD also confirmed that despite nutritional assessments which were completed during the period of weight loss, the plan of care was not revised to include any interventions related to the resident's nutritional status, weight and any risks associated with nutritional care. [s. 6. (11) (b)] (130)

WN #4: 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 failed to ensure that where the Act or this Regulation required the licensee of a long term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure,strategy or system was in compliance with and was implemented in accordance with applicable requirements under the Act and in accordance with s. 11. (1), that required a long term care home to ensure that there was an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents. The home's policy titled: Weights and Heights, revised December 2017, indicated the purpose of the policy was to provide staff with the practice requirements for monitoring residents for weight gain or weight loss, including referral to the interdisciplinary team for interventions. The policy directed care staff to record the weight in kilograms, staff initial and the variance on the Weight Tracking Record. If a re-weight was required as there had been a gain or loss of 2.0kg or greater from the previous weight, staff were to reset the scale and re-weigh the resident. Staff were to record the re-weigh and re-weigh variance if applicable on the Weight Tracking Record. The policy directed Registered staff to review the Weight Tracking Record for the current month to ensure accuracy and completeness by the 7th day of every month and consider possible re-weigh if variances seemed questionable; ensure all outstanding weights were completed and all weights were put in Point Click Care by the 10th day of the month. The policy further directed staff to assess for possible causes for weight loss/gain, i.e changes in level of activity, quantity of food consumption or effects of medication on the resident's appetite and initiate a referral to the Registered Dietitian.

A) The plan of care for resident #091 had a RD established goal weight range (GWR).

According to the home's Weight Tracking Record, the resident had an identified weight on an identified date in 2017. The recorded weight one month later on a subsequent identified date in 2017, indicated a loss of greater than 2.0kg. Staff #506 confirmed in an interview that there had been no re-weigh done on an identified date in 2017, when the resident's weight loss exceeded 2.0kg.

B) The plan of care for resident #038 revealed their RD established a GWR. A review of the Weight Tracking Record for resident #038 revealed that their recorded weight was on an identified date in 2017. The resident's had subsequent recorded weights one month and two months later on identified dates in 2017 that indicated a weight change of 2.0kg or greater. Staff #506 confirmed in an interview that there were no re-weighs completed on identified dates in 2017, despite significant weight changes from the previous weights.The RD confirmed in an interview that the previous RD had completed an assessment of the resident on an identified date in 2017, because the resident's quarterly summary was scheduled for completion. The RD confirmed there had been no referrals sent to the RD in response to the identified weight variances. The home's policy titled: Weights and Heights, revised December 2017, was not complied with regarding re-weighs and referrals to the RD. [s. 8. (1) (a),s. 8. (1) (b)] (130)

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A) On an identified date in 2017, a critical incident report was submitted by the home indicating resident #091 had a fall which resulted in an injury while staff was present.
A clinical record review revealed that at the time of the incident resident #091 was identified as a high risk for falls and had fall prevention strategies in place.
During an interview on an identified date in 2018 registered staff #501 acknowledged that resident #091 was a high risk for falls and confirmed that the home failed to ensure staff use safe positioning techniques when assisting resident #091. [s. 36.] (682)

Issued on this 31st day of January, 2018

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

Original report signed by the inspector.