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 14, 2022	2022_931821_0004	016883-21	Critical Incident System

Licensee/Titulaire de permis

Chartwell Master Care LP
7070 Derrycrest Drive Mississauga ON L5W 0G5

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

Chartwell London Long Term Care Residence
2000 Blackwater Road London ON N5X 4K6

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

PETER HANNABERG (721821)

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): February 7-9, 2022.

The following Critical Incident intakes were completed within this inspection:

Related to falls prevention:

Critical Incident Log #016883-21.

IPAC checklist version A2 was also completed at the time of the Critical Incident inspection. Inspector Debbie Warpula (577) was also present during the inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, a Physiotherapist, two Registered Practical Nurses, three Personal Support Workers, and two Housekeepers.

The inspector(s) conducted observations of the home, including meal services, cleaning processes, and staff-resident interactions. The inspector(s) also reviewed residents' clinical records, pertinent policies, a program evaluation, and the Critical Incident Report.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Falls Prevention
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care plan for a resident was updated upon reassessment to include certain falls prevention interventions after they were initiated.

A resident had a fall which resulted in an injury. Certain falls prevention interventions were initiated as a result of the fall. These interventions were not documented in the resident's care plan.

Sources: The resident's care plan, progress notes, and interviews with a Registered Practical Nurse and the Director of Care. [s. 6. (10) (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 that all falls prevention interventions are documented in a resident's care plan upon assessment or reassessment, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that hazardous cleaning products were inaccessible to residents at all times.

While conducting observations in the Magnolia Court Home Area, a housekeeping cart was found unattended. Inspector(s) witnessed three bottles of a cleaning product had been left on the cart where it was accessible by residents. When the Housekeeper returned to the cart, an interview determined that the product was a floor cleaner, Lustrex, which was labelled as corrosive.

Sources: direct observation and interview with a Housekeeper. [s. 91.]

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 hazardous cleaning products are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident hand hygiene was provided before and after meal time as required by the home's Hand Hygiene Program.

The home's Hand Hygiene Program Policy (LTC-CA-WQ-205-02-04) states that residents should be encouraged to clean their hands with alcohol-based hand rub before and after meal times. Inspector(s) observed that resident hand hygiene was not offered or encouraged by staff members in the Magnolia Court dining room before or after one lunch meal.

A Personal Support Worker (PSW) stated that the residents were not provided hand hygiene at that meal, and that resident hand hygiene was not done consistently before or after meals.

Sources: Hand Hygiene Program Policy (LTC-CA-WQ-205-02-04), direct observation, and an interview with a PSW. [s. 229. (4)]

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 residents are offered and/or encouraged to perform hand hygiene before and after meals, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a Critical Incident System (CIS) report was updated with actions taken in response to the incident, including the outcome or current status of the individual involved in the incident.

The CIS report was related to a resident fall resulting in an injury. The home's Critical Incidents (CI)/Reportable Incidents Policy (LTC-CA-WQ-100-05-04) stated that the Director of Care or Administrator or delegate was responsible for making amendments to the Critical Incident report.

A review of the CIS report showed that no amendments had been made after it was submitted. The Director of Care (DOC) stated in an interview that the CIS report should have been amended to include the date the resident returned from hospital with their current status.

Sources: The CIS report, Critical Incidents (CI)/Reportable Incidents Policy (LTC-CA-WQ-100-05-04), and an interview with the DOC. [s. 107. (4) 3. v.]

Issued on this 14th day of February, 2022

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

Original report signed by the inspector.