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
Aug 9, 2018	2018_591623_0012	017198-18	Critical Incident System

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): July 23, 2018

The following log was inspected: log #017198-18 for a Critical Incident Report - related to a fall that caused an injury, resulting in a significant change in the resident's health status.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Nurse(s) (RN), Registered Practical Nurse(s) (RPN), Personal Care Provider(s) (PCP).

In addition, during the course of this inspection the inspector reviewed clinical health records, the licensee's internal investigation notes, staff education records, and related policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Related to log #017198-18 for a Critical Incident Report

A Critical Incident Report (CIR) was submitted to the Director, for an incident that caused injury to a resident for which the resident was taken to the hospital and resulted in a significant change in the residents health status.

The CIR indicated that on a specified date, resident #001 was walking very fast in the hallway, with a shuffling gait. PCP #101 asked resident #001 to slow down, but the resident tripped and fell. Resident #001 was able to grab the handrail and lower themselves to the floor, PCP #101 reported that the resident did not hit their head. RN #100 responded to the witnessed fall, a head to toe assessment was completed. Documentation indicated that an assessment was completed by RN #100 and the resident expressed concern about an identified body part. Resident was assisted to stand by two staff and gingerly walked to their room and placed into bed.

Review of the clinical records for a specified time period, for resident #001 indicated that the following was documented:

On a specified date and time RN #100 documented that the RN was at the information station when heard PCP #102 call for assistance. PCP #102 reported that resident #001 was on the floor. RN went to assess, resident was sitting on the floor. PCP #101, indicated the resident tripped over the carpet, was able to grab the handrail to break their fall and lowered them self to the floor. PCP #101 indicated that resident #001 did not fall to the floor and did not hit their head. The resident was wearing proper fitting shoes. RN #100 completed an assessment of the resident, they were alert with good ROM to all extremities. No bruising, no redness was noted. The resident was walked to their room with assistance.

On the same date, RPN #103 documented that after lunch resident #001 was walking to their room where their gait became unsteady, the resident lost their balance and in what seemed like slow motion lowered them self with staff around as witness, to the floor. RN #100 was notified, an assessment was completed and resident was assisted to their feet and assisted to their room. RPN #103 gave resident medication for pain. PCP #101 reported that the resident was displaying non-verbal signs of pain, facial grimace, moaning and groaning. Resident #001 reported pain in a specific area and stated they cannot walk. RPN #103 assessed and again nothing seemed out of place or of concern, resident repeated all the same concerns to the RPN. RPN #103 provided a mobility device for resident to use as they claimed they could not walk. Resident #001, was assisted to the dining room in the mobility device, where they continued to display signs of pain in a specific area. RPN #103 asked how the resident was feeling when giving routine dinner medications. Resident stated "I cannot walk anymore". RPN #103 notified RN #100 who was updated on the behaviors.

The following day at a specified time, RPN #103 documented that resident #001 was assessed. Resident stated they had pain all over. PCP #101 required the assistance of other staff to provide care to resident #001. Three times staff tried to assist resident to stand but the resident was using all their strength to force themselves down instead of helping PCP's. RN #100 was made aware of residents complaints of pain. RPN #103 administered pain medication along with routine medications for any discomfort.

On the same date at a specific time, RN #100 documented that staff reported to writer that resident #001 had been complaining of pain since the incident yesterday. Staff reported that resident #001 refused to walk therefore was placed in the mobility device to

take them to the dining room. Staff reported that resident refused to get up on their own multiple times when in bed. RN completed a head to toe assessment on resident #001. Resident was inconsistent with the location of their pain, indicating several locations. RN had asked the resident to rate their pain on a scale, but they were not able to answer. During the RN's interaction with the resident they verbalized a fear of falling and RN shared this with staff. RN had also asked staff to stop asking the resident about their pain but rather wait for them to verbalized it or monitor body language for signs of pain.

The following shift, RPN #104 documented that they received resident #001 sitting in the mobility device near an identified area. Resident was sitting comfortably, no signs of pain or facial grimacing but when staff asked if they wanted to walk, they complained of pain in. The resident could not point where they felt the pain, then. The resident was able to move and lift their legs comfortably, no abnormality noticed. The resident was transferred using a transfer device.

The next day at a specific time, Physiotherapist (PT) #105 documented that they received a verbal request from nursing staff to provide a loaner mobility device. PT went to see resident #001, the resident refused to stand stating "I cannot stand" but unable to provide reason. A mobility device was provided. PCP staff made aware.

The same day, RPN #106 documented that resident #001 refusing to stand up on their own and staff needing to use a transfer device to assist. Resident continues to state different areas on their body that are in pain. Nursing staff tried multiple times to get resident to stand and weight bear, resident continues to refuse. While in the dining room resident refused to eat, when questioned why they are not eating resident stated "I can’t ". Physiotherapy was contacted and a mobility device was provided for resident #001. No sign of injuries noted at this time. Resident able to lift both legs when sitting in the mobility device. No attempts made by resident to stand.

Three days following the initial fall, RN #107 documented that resident #001 is still having difficulty with mobility. Resident has refused to stand up for staff and therefore had to be transferred using a transfer device. Resident is complaining of general pain all over. When the resident is sitting in the mobility device they are able to reposition, and move their legs around freely without showing any indication of pain. When writer attempts to assess, the resident becomes very guarded and states it hurts before the RN had even touched them. The RN, with the assistance of staff, was able to get the resident to stand up for a few minutes holding onto a mobility device and the corridor railing. The resident expressed a fear of falling instantly and refused to attempt at taking a step.

On the same day, RPN #108 documented that resident #001 sustained a fall three days prior, with no apparent injury however tripped and lowered them self to the floor. Resident has since required a mobility device due to their fear of falling and stating that they couldn't walk. Staff have used a transfer device for transfer purposes. RPN #108 had noted a decline in resident #001's eating since the fall, resident had refused to eat meals but would eat dessert and drink fluids. Resident had also become more incontinent, also requiring assistance with dressing. Resident had reported insomnia well complaining of discomfort and not being able to rest. RPN #108 documented that it was very difficult to determine where residents pain was, often indicating different locations. RPN #104 assessed resident and indicated that resident had pain "everywhere/ all over." RPN #108 reviewed with RPN #104 and RN #107 that resident's had been using pain medication and indicated a pain scale ranged from 4-9. Physician was contacted by RPN #104, an order for as needed pain medication was received as well as a specific test.

Four days after resident #001 fell, RPN #108 documented that when the PCP and RPN took the transfer device to the resident room to transfer them into a mobility device, the resident stated they did not want to get up. Resident #001 was observed to attempt to get up but was unsuccessful. RPN #108 also observed resident move in the bed diagonally using upper body strength only. Resident indicated they were in pain to PCP. RPN administered medication, the resident rated their pain 10/10 and stated the pain was everywhere. RPN #108 assess resident, when the RPN touched a specific area, the resident stated they were in pain, and the area was warm to touch. Range of motion was attempted, however resident was resistive and would not lift/bend their legs up. RN #100 was made aware, the physician was contacted and completed an assessment of the resident. Additional tests were ordered.

On the same day, RN #100 received a call from diagnostic imaging indicating that the result of a specific test showed probable injury. The physician made aware of the specific test result, new orders were received.

During an interview on a specific date and time with Inspector #623, RN #100 indicated that they were sitting at the desk in an identified area, on a specified date, when the fall occurred with resident #001. RN indicated that they heard a commotion in the hallway. The PCP #101 was with the resident at the time, the PCP indicated that the resident didn’t really fall, they lowered them self to the floor. RN #100 indicated that they did an assessment, the resident was talking and joking with staff during the assessment. The RN indicated that PCP #102 and RN #100 helped the resident off the floor and walked

them to the bed. RN #100 indicated then when the assessment was completed, there was no indicated of injury noted. RN #100 indicated that the following day was when resident #001 refused to walk. RN #100 indicated that they felt that resident #001 was scared of falling again that this was the reason they were refusing to walk, not that they couldn't walk. A head to toe assessment was completed again, RN #100 indicated that they checked resident #001 and they indicated they had pain but it was in various locations. RN #100 indicated that a mobility device was provided for resident #001 and pain medication. RN #100 indicated that two days later, the resident was still refusing to walk and was in a lot of pain, so nursing staff had received an order for a specific test to be completed . RN #100 indicated that had they been informed at the time of how hard the resident actually fell, they would have sent the resident to the hospital if the resident was complaining of pain and not weight bearing. RN #100 indicated that based on the information they had, the assessments that they completed and the history of resident #001's behaviours, a transfer to hospital for further assessment was not required. The resident was indicating that they were in pain, but never identifying a specific location,RN indicated that they felt this was resident #001's usual behaviour and not new.

During an interview with Inspector #623, PCP #101 was assigned to monitor resident #001 on the date of the incident. The PCP and resident #001 were walking in the hallway. The resident was starting to walk faster, PCP told the resident to slow down. As the fall occurred, the resident appeared to hold onto the handrail as they were falling. The resident twisted their body as they fell to the carpet. PCP #101 indicated that they believe the fall was not that hard. The PCP indicated that resident #001 could not give a reliable or consistent answer, when asked if they were in pain they would give a different location of pain every time. After the fall, resident #001 was refusing to walk at times, but would also still attempt to transfer themselves with little success.

On a specific date and time, during an interview with Inspector #623, the Director of Care (DOC) indicated that resident #001's fall occurred on a specific date. The resident complained of pain over the next few days, but could not identify the exact location. The physician was notified three days late, and a specific test was ordered as well as medication for pain control. A further specific test was ordered the following day, and routine pain medication was also ordered. The second specific test revealed that the resident had an injury. The DOC indicated that when reviewing this incident for the CIR investigation, they had identified concerns as a result of this, education has been provided for all nursing staff related to recognizing the non-verbal cues of residents when experiencing a change in condition. The DOC indicated that it is the expectation of the licensee, when a resident experiences a fall and there is a change in condition identified,

that the nursing staff would notify the physician for further direction or transfer the resident to the hospital for assessment.

RPN #104 and #108 were not available for interview during the inspection.

The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other. When resident #001 experienced an incident on a specified date, documentation indicated that for three days resident #001 refused to ambulate, required a transfer device for transfers, expressed that they were in pain verbally and with non-verbal cues, began to refuse meals and became increasing more incontinent. Physiotherapy was verbally notified, and did not complete an assessment of the resident when they provided a mobility device. The physician was not notified of the change in resident condition until three days after the incident occurred. [s. 6. (4) (a)]

2. The licensee has failed to 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 the resident's care needs change or care set out in the plan is no longer necessary.

Related to log #017198-18 for Critical Incident Report (CIR)

A Critical Incident Report (CIR) was submitted to the Director on a specific date and time for an incident that caused injury to a resident for which the resident was taken to the hospital and resulted in a significant change in the residents health status.

The CIR indicated that on a specified date, resident #001 was walking very fast in the hallway, with a shuffling gait. PCP #101 asked resident #001 to slow down, but the resident tripped and fell. Resident #001 was able to grab the handrail and lower themselves to the floor, PCP #101 reported that the resident did not hit their head. RN #100 responded to the witnessed incident, a head to toe assessment was completed. Documentation indicated that range of motion to all extremities was good, no injury noted. Resident was assisted to stand by two staff and walked to their room and placed into bed.

Review of the progress notes for a specified time period, indicated the following:

On a specific date and time, three days after the identified incident, RPN #108

documented. Resident #001 experienced an incident on a specific date and time - with no identified injury. Resident has since required a mobility device due to their fear of falling and stating "I can't using my legs, I'm in pain." Staff have used a transfer device for transfer purposes. RPN #108 has noted a decline in resident #001's eating since the incident. Resident has also become more incontinent, also requiring assistance to dresss. Resident has reported to not be sleeping well complaining of discomfort and not being able to rest. RPN #108 documented that it is very hard to determine the location of the residents pain. RPN #104 assessed resident and indicated that resident has pain "everywhere/ all over." RPN #108 reviewed with RPN #104 and RN #107 that resident's has been using pain medication and their pain scale ranges from 4-9. Physician was contacted by RPN #104 orders were received for pain medication and a specific test was ordered.

Review of the written plan of care indicated the following:

Risk of falls –identified resident #001 was at risk for falls, interventions were identified to prevent falls or reduce injury.

Pain – plan of care initiated six days after the incident, included staff are to identify specific non-verbal signs of pain, Administer medication as per orders.

Transferring – interventions indicated resident #001 was independent with transfers, requires occasional supervision. Revised five days following the incident to identify the need of a transfer device and two staff for all transfers.

Locomotion – interventions indicated resident #001 was able to walk without assistance. Revised six days following the incident, to identify the use of a mobility device with supervision, cuing and guided maneuvering.

Decreased appetite – Care plan was not initiated until 13 days following the incident.

On a specific date and time during an interview with Inspector #623, PCP #101 indicated that resident #001 verbalized that they were in pain after the incident, but could not give a reliable or consistent answer of the location of the pain, the resident would identify a different location every time they were asked. After the incident, resident #001 would still attempt to transfer themselves, the resident was using a mobility device and required a transfer device for transfers. PCP #101 indicated that the day following the incident, resident #001 was in bed all day, and were not walking or willing to stand. The resident

could not bear weight. The PCP indicates that the RN and RPN were aware of the change in condition of the resident.

On a specific date and time during an interview with Inspector #623, RN #100 indicated that when they returned to work four days following the incident, they were aware of the change in status of resident #001, including requiring a wheelchair and a mechanical lift for transfers, as well as the increase in pain, increase in incontinence and reduced intake at meals. RN #100 indicated that they did not review and revise the residents plan of care when the resident's care needs changed.

During an interview with inspector #623, the DOC indicated that the expectation is the plan of care will be reviewed and revised when a residents care needs changes.

The licensee failed to ensure that the plan of care for resident #001 was reviewed and revised when the resident's care needs changed following an incident resulting in an injury. [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 by ensuring that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other. Also, by ensuring that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary., to be implemented voluntarily.

Issued on this 28th day of August, 2018

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

Original report signed by the inspector.