Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 18, 2019	2019_671684_0039	013716-19, 016940-19, 018245-19	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

SHELLEY MURPHY (684), HILARY ROCK (765), LOVIRIZA CALUZA (687), SYLVIE BYRNES (627)

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): November 4-8, 2019.

The following intakes were inspected upon during this Critical Incident System Inspection:

Two logs related to falls preventions.

One Log related to staff to resident neglect.

Complaint inspection #2019_671684_0038 was conducted concurrently with this Critical Incident System inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Director of Cares (ADOC), Environmental Service Manager (ESM), Physiotherapist (PT), Unit Clerk, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Worker (PSW), Environmental Aide, Maintenance Staff, Physio therapy assistant (PTA), residents and families.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, complaint records, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 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	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 resident was 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 was no longer necessary.

A Critical Incident System (CIS) report was submitted to the Director related to a change in condition for resident #003.

During a review of the CIS report, which occurred on a specified day in 2019, Inspector #684 noted the care plan was updated with specific safety interventions for resident #003 after the incident.

Inspector #684 reviewed a number of progress notes for resident #003 from a specified date in 2019, which had a specific interventions for safety while in bed.

Inspector #765 interviewed Personal Support Worker (PSW) #111, and asked where they find information related to a resident's care needs; PSW #111 responded, on Point of Care (POC) and in the care plans.

Inspector #684 interviewed Registered Practical Nurse (RPN) #110 and PSW #109, who both stated that resident #003 had specific interventions in place for safety after the incident which lead to a change in their condition.

Inspector #684 reviewed the care plan for resident #003 and noted that a specific intervention was put in the care plan for resident #003 on a specified date in 2019.

Upon review of the home's policy "Developing a Plan of Care", RET-CA-ALL-215-04-01, last revised May 2016, it stated, care plans are evaluated and revised as resident care

needs change or on designated target dates.

Inspector #684 and Assistant Director of Care (ADOC) #124 reviewed the care plan for resident #003. The ADOC stated the care plan that had a specified date range in 2019, did not show the safety intervention, and any changes that were made between the specified dates in 2019 should be noted in this care plan. ADOC #124 also stated, that they added the specific intervention on a specified date in 2019, based on the revision date noted in the care plan. The ADOC also stated anything that was a plan or strategy should be part of the care plan, and that it could have been implemented on the floor but was not put into the care plan. [s. 6. (10) (b)]

2. A CIS report was submitted to the Director, related to resident #002's incident with change in condition.

During a review of the resident #002's Minimum Data Set (MDS) Assessment from a specified date in 2019, Inspector #765 noted that the MDS assessment identified resident #002 as having a change in condition due to the incident on a specified date in 2019.

Inspector #765 reviewed resident #002's care plan from before and after the incident. The care plan did not indicate the safety interventions. The care plan had two contradicting interventions for staff to follow while providing care for resident #002.

Inspector #765 reviewed resident #002's progress notes and identified, a note which indicated a specific intervention was being utilized. Inspector #765 noted a PT progress note from a specified date in 2019, which indicated the need for a specific intervention for resident #002.

Inspector #765 interviewed PT #123, and they indicated that their assessment interventions should be noted in the care plan and that the care plan was to be updated by the registered staff.

During a review of the investigation interview notes by Inspector #765, they noted during the interview between ADOC #124 and PSW #111, there was a note which indicated that the specific intervention that was to be utilized for resident #002.

Upon review of the home's policy "Developing a Plan of Care", RET-CA-ALL-215-04-01, last revised May 2016, it stated, care plans are evaluated and revised as resident care

needs change or on designated target dates.

During interviews with Inspector #765, PSW #111, PSW #119 and RN #112, indicated that resident #002 had specific interventions utilized post incident. PSW #111, stated that the interventions should be in the care plan. PSW #119 and RN #112 stated that when a resident had a change in condition, this should be indicated in their care plan.

ADOC #124 and #125 confirmed to Inspector #765 that the interventions for resident #002 should have been in their care plan and they were not. They also confirmed that there was a physician's order for a specific intervention for resident #002, that should be indicated in the care plan, as well as the interventions that the PT made during their assessment. ADOC #124 and #125 indicated that the old interventions that were no longer to be used should have been removed from the care plan. [s. 6. (10) (b)]

3. Resident #017 was identified as having multiple areas of altered skin integrity, during a review of their health care records.

Inspector #627 reviewed the resident's plan of care, (medical orders, care plan and assessments) and identified that resident #017 had altered skin integrity.

Inspector #627 reviewed resident #017's care plan in effect at the time of the inspection for the focus of altered skin integrity, which indicated the use of a specific intervention for resident #017.

Inspector #627 observed resident #017 and noted that the specific intervention was not being utilized.

Inspector #627 reviewed the home's policy titled," Clinical Care", RET-CA-ALL-215-04-01- "Developing a Plan of Care", last revised May 2016, which indicated that "development of a plan of care was the responsibility of the Health and Wellness Manager (HWM) and/or designated registered staff. Care plans are evaluated and revised as resident care needs change or on designated target dates".

Inspector #627 interviewed PSW #128 who informed the Inspector what care they provided for resident #017's altered skin integrity. They stated that at one time, the specified intervention was used for resident #017. PSW #128 stated that the resident's care plan indicated the specific intervention; however, it was not utilized all the time as the intervention could at times have a negative impact on the resident. PSW #128 stated

that new staff members would not be aware of this if they read the care plan. Together, PSW #128 and Inspector #627 went to the resident's room and spoke to the resident about their health status and their altered skin integrity. PSW #128 implemented the specified intervention for resident #017's altered skin integrity. Inspector #627 asked the resident if this helped, to which the resident replied, "a little bit".

Inspector #627 interviewed RN #115 who stated that resident #017 had a change in condition. RN #115 stated that the resident had altered skin integrity for which the PSWs implemented specific interventions. The RN further stated that the specified intervention "remained active" and that they were not aware that staff had been removing the intervention due to a change in the resident's condition. They stated that the care plan was to be updated by registered staff as needed.

Inspector #627 interviewed RPN #129, who was a member of the wound care team. RPN #129 stated that resident #017 had a change in condition. The RPN stated that the care plan indicated that a specific intervention that was to be used; however, at times when the resident's condition changed, this intervention could be a risk for them. RPN #129 further stated "I have to be honest, the care plan needs to be updated as it does not indicate when the specific intervention should not be used. RPN #129 stated they would update the care plan to indicate when the intervention was to be used.

Inspector #627 interviewed ADOC #125 who stated that the expectation regarding care plans was for the policy to be followed and for front line staff to follow the care plan. The ADOC acknowledged that resident #017's care plan should have been updated to indicate when the specific intervention was to be used. [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 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 changed or care set out in the plan is no longer necessary., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

A CIS report was submitted to the Director on a specified date in 2019, related to an incident involving resident #002.

Inspector #765 reviewed the assessments completed on specified dates in 2019, which indicated resident #002 had altered skin integrity. Another assessment completed on a later specified date indicated that the altered skin integrity had worsened.

Inspector #765 reviewed with RPN #133 the initial assessment from the specified date in 2019, and the second assessment from a later date in 2019. RPN #133 confirmed after reviewing the assessments that resident #002's altered skin integrity had worsened from the first date to the second in 2019.

Inspector #765 reviewed the prescriber order form which indicated that a specific intervention was ordered by the physician on a specified date in 2019. A physician progress note from a specified later date in 2019, indicated that resident #002 still had the same intervention in place and the newly ordered intervention had not been implemented.

PSW #111 stated in an interview with Inspector #765 that resident #002 had a specified intervention in place when they had a change in condition, and RN #112 indicated to Inspector #765 that resident #002 did not receive the ordered intervention immediately as per prescribed order.

Upon review of the home's policy "Skin Care Program Overview", last revised December 2017, it states, using alternative pressure surface to relieve or reduce mechanical causes of pressure as preventative measure.

Inspector #765 interviewed the Environmental Services Manager (ESM) #103 who confirmed that they were aware of the order written on a specified date in 2019. ESM #103 provided the Inspector with a document which showed that the equipment required for the specific intervention was available on the date of the order for resident #002; however, ESM #103 informed the Inspector that the intervention was not provided to resident #002 for a specified period of time.

Inspector #765 reviewed the initial skin assessment from a specified date in 2019, and the next assessment dated a specific date, with ADOC #125. Upon review of the assessments, ADOC #125 confirmed to Inspector #765 that resident #002's altered skin integrity had worsened. ADOC #125 indicated to Inspector #765 that their expectation of an as soon as possible (asap) physician order would be for it to be implemented within 24 hours. [s. 50. (2) (b) (ii)]

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 that ensures that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A CIS report was submitted to the Director related to an incident which caused a change in condition for resident #003.

Inspector #684 reviewed resident #003's progress notes and was unable to locate a post fall assessment for the incident which occurred on a specified date in 2019.

Inspector #684 reviewed the home's investigation file for the CIS, which had a typed letter that stated-met with RN #127 regarding no post fall assessment and analysis for resident #003s incident on a specified date in 2019. RN #127 stated they forgot to do the post fall assessment, but completed another type of documentation for the incident. RN

#127 was directed to do a late entry for the missing post fall assessment.

Inspector #684 reviewed the home's policy titled "Resident Falls Prevention Program" last revised June 2019, which stated registered staff will complete Section 1 of the Post Fall Assessment and Analysis in PCC.

During an interview with Inspector #684, RPN #106 stated when a resident had fallen they, assessed the environment, the residents pain level, completed a head-to-toe assessment, range of motion (ROM), complete post fall analysis, and the Scott fall assessment.

Inspector #684 interviewed ADOC #124 (falls lead) regarding the home's falls process. The ADOC stated that the registered staff complete a resident assessment, post fall analysis, they gathered information from staff during the post fall huddle and they completed the second portion of the analysis tool. The ADOC further indicated staff did pain, and skin assessments if necessary, as well as notify the physician and POA. Inspector #684 asked if the post-fall analysis and post fall assessment were they same thing, ADOC #124 confirmed they were the same thing.

Together, Inspector#684 and ADOC #124 reviewed the investigation file, ADOC #124 stated they realized the nurse had not completed a post fall analysis for resident #003. Inspector #684 asked if it was their expectation that a post fall analysis be completed after every fall, and the ADOC stated "yes for sure". [s. 49. (2)]

Issued on this 20th day of November, 2019

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

Original report signed by the inspector.