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 27, 2020	2020_694166_0007	021708-19, 000058-20, 000405-20, 000426-20, 000729-20, 000882-20, 001807-20	Complaint

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

CAROLINE TOMPKINS (166), CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 3, 4, 5, 10,11,12,13, 2020.

The following complaints related to Registered Nurse 24/7 staffing, the management of responsive behaviours, dealing with complaints, resident care and infection control were inspected concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, Physicians, Behavourial Support Ontario staff members (BSO), the Nursing Consultant, Assistant Director of Care (ADOC), Administrator, Environmental Service Manager (ESM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Providers (PCP), Business Manager and the Nursing Unit Clerk.

During the course of this inspection, the Inspectors reviewed specific residents' progress notes, plans of care, RN and RPN schedules, reviewed the licensee's policies and procedures related to infection control, skin and wound care, management of complaints, observed resident to resident interactions and staff to resident interactions during the provision of care.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
5 WN(s)
4 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The Director received an anonymous complaint which included a concern that a specific directive related to a resident's care had not been followed.

Inspector #166, reviewed the progress notes for specific dates, related to the assessment of resident #003’s changing health status, which indicated that the resident had not been not been feeling well, food/fluid intake had declined and during a transfer, the Personal Care Providers (PCP) reported that the resident moaned as if in pain.The resident’s family was updated by the nursing staff.

Review of resident #003's progress notes by Inspector #166, indicated that on another specific date, RPN #115 documented that during residents' observation rounds by the PCPs, RPN#115 was informed that resident #003 had a change in condition. RPN #115 assessed the resident and the physician was notified.

During a telephone interview with Inspector #166, RPN #115, indicated, that they were the RPN who assessed resident #003, on the specific date when the resident #003 had a change in condition. RPN #115 indicated, there was one other RPN working that shift and there was no RN in the home at the time.

RPN #115, indicated that the previous shift report did not indicate that resident #003 was palliative or required any increased monitoring. When the PCPs made their observation rounds at a specific time, resident #003 was found to be sleeping and no distress was observed. When the PCPs made their observation rounds an hour later, the PCPs notified RPN #115 that the resident's condition had changed.

During the interview with Inspector #166, RPN #115, indicated that they were not aware of the specified directive indicated in the resident's plan of care.

The licensee has failed to ensure that the care set out in resident #003's plan related to the resident's specified directive and the resident's Communication of Prior Expressed Wishes document was provided to the resident as directed in the plan. [s. 6. (7)]

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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

The Director received two separate complaints related to no Registered Nurse (RN) staffing in the home on specifically identified shifts. The complainants alleged that the home continued to have only a Registered Practical Nurse (RPN) on the identified shifts and that sometimes the RPNs were from a nursing agency who were not familiar with the residents and the home.

Inspector #166, reviewed the RN schedule for a specific period of time which indicated there was no RN coverage on seven identified dates and shifts.

Inspector #166, reviewed the licensee's Staffing Contingency Plan for Registered Nurses which indicated:
A Chartwell employed RN must be in the building at all times (24/7). Agency staff can compliment the Chartwell RN in the building, but an RN must be present and working in the role as the RN in the building at all times and if no staff are available, the on call

manager (DOC/ADOC)is to be present in the building to cover the RN shift.

During separate interviews with the ADOC, Nurse Unit Clerk and the Business Manager, over the course of this inspection, the RN /RPN schedule was verified and confirmed that on specific dates and shifts, there was no RN, who was both an employee of the licensee and a member of the regular nursing staff on duty and present in the home. The identified dates on which that there was not an RN in the building was not due to an unforeseen situation of a serious nature that prevented an RN from getting to the long-term care home.

During separate interviews with Inspector #166, RPN #112 and RPN #115 confirmed that on the dates and shifts that they worked, there was no RN on duty and present in the home.

During an interview with RN #105, the RN confirmed that on a specific date, RN #105 came into work early to assist RPN #115, who was unfamiliar with the procedures to be followed related to the care of a resident. There was no RN on duty and present in the home until RPN #115 called RN #105 for assistance at the end of the shift.

The licensee failed to ensure that on the confirmed identified dates and shifts reviewed, there was at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home on duty and present in the home at all times. [s. 8. (3)]

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 shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations, to be implemented voluntarily.

WN #3: 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 :

The licensee has failed to ensure that a resident exhibiting altered skin integrity has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

During the inspection of a complaint received by the Director related to the management of a specific type of skin irritation in the home, Inspector #194 reviewed the clinical health records for resident #001.

During an interview with ADOC #100, Inspector #194, was informed that the Treatment Administration Record (TAR) was to be used to complete the weekly skin assessments of identified residents with impaired skin integrity, including rashes.

Review of the clinical health records for resident #001 indicated on a specific date, the resident received a treatment for a skin irritation.

Review of resident #001's TAR for the period of four months was completed by Inspector #194.

During an interview with Inspector #194, RPN #120 verified that the TARS for resident #001 on a specified date had been signed as completed. Review of the Point Click Care (PCC) system was completed by RPN #120 and Inspector #194 and no evidence of a weekly skin assessment could be located for that specified date.

During an interview with Inspector #194, RPN #125 verified that they were working when resident #001's weekly skin assessment was due to be completed. The RPN, indicated, if a weekly skin assessment was not signed off as completed in the TARs, it was determined that the assessment was not completed for the resident.

The licensee has failed to ensure that resident #001, who had been exhibiting altered skin integrity related to an irration was reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

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, 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, and is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: 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. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

The licensee shall ensure that on every shift, symptoms indicating the presence of infection in residents are monitored in accordance with evidence based practices.

During this inspection of number of complaints were received by the Director, related to residents' with a skin irritation . Inspector #194, interviewed the ADOC, who was also the Infection Control Coordinator. During the interview, Inspector #194 was informed that the home monitored daily infections using their “Daily Infection Surveillance Tracking sheets”. The ADOC, provided copies of the Daily Infection Surveillance Tracking sheets for the unit affected with the specific skin irritation for the period of four months. The ADOC also provided Inspector #194 with a copy of the licensee’s “Daily Infection Surveillance” policy.

Inspector #194, reviewed the "Daily Infection Surveillance" policy #LTC-CA-WQ-205-03-02, which indicated:
Registered staff will review shift report and daily surveillance records to identify residents with infectious symptoms, observe and assess residents for signs and symptoms of illness or possible infections.
When symptoms, such as rash or new areas of reddened, scabbed or excoriated skin are identified, the Registered staff are to record the resident name on the Daily infection Surveillance form.
Subsequent shifts are to continue assessing and observing residents with symptoms, recording findings on the Daily infection Surveillance Form.
In the event the resident does not display any symptoms, Registered staff are to place a check mark on the appropriate shift box. Once there are three consecutive shifts with check marks on the Daily Infection Surveillance form, ongoing recording ends.

Review of resident #001, #005, #013 and #016's progress notes, Medication Administration Records (MAR) and the Daily Infection Surveillance Tracking sheets for a period of four months related to the presence of a specific skin irritation indicated, the Daily Infection Surveillance Tracking sheets were incomplete as the shift to shift assessment to identify symptoms of the skin irritation of the above noted residents had not been completed. Ongoing documentation in Point Click Care, using progress notes related to status and actions taken had not been completed and it was unclear when the isolation precautions during an identified month were implemented.

The licensee failed to ensure that on every shift, symptoms indicating the presence of a skin irritation on the identified residents were monitored. The Daily Infection Surveillance sheets for monitoring symptoms which indicated the presence of a skin irritation for the period of four months during an outbreak at the home had not been completed for residents #001, #005, #013 and #016. [s. 229. (5) (a)]

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 on every shift, symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

Review of the licensee's complaint policy "LTC-CA-WQ-100-05-09 indicated:

Verbal complaints that take longer than 24 hours to resolve require written documentation of the investigation and a written documentation of the communication associated with the complaint and the investigation.

During a complaint inspection, the SDM for resident #005 informed Inspector #194 of a verbal complaint made to the home related to a medication. The SDM indicated that resident #005 had been itchy and the SDM had requested that the physician order a specific medication for the itch, which the SDM paid for as that medication was not covered under the Ontario Drug Benefit (ODB). The SDM inquired with RPN #120, if the medication had been administered and was informed that the medication had been received several days after it had been ordered from pharmacy and that the physician had been ordered to be administered as needed. RPN #120, advised the resident's SDM that the medication was not administered to the resident and had been discontinued.

The SDM for resident #005 indicated that on a specific date, they had spoken to the ADOC related to the medication not administered to the resident. The SDM for resident #005 informed Inspector #194, that no resolution to their complaint had been provided by the home.

During interview with Inspector #194, the ADOC confirmed receipt of a verbal complaint by the SDM for resident #005 related to the medication. The ADOC indicated to Inspector #194 that the SDM was informed that the information received would be forwarded to the ADOC #127 responsible for the unit where resident #005 resided. The ADOC indicated that the complaint was returned to them for completion when ADOC #127, was no longer with the home. The ADOC indicated that the SDM for resident #005 had now been contacted with resolution to the complaint, four months after the complaint was lodged.

During interview with Inspector #194, the Administrator reviewed the homes verbal complaint log and verified that no verbal complaint involving resident #005 had been documented.

The licensee failed to ensure that a verbal complaint made by resident #005's SDM to the ADOC, on a specific date was investigated and a response provided within 10 business days. [s. 101. (1) 1.]

Issued on this 3rd day of March, 2020

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

Original report signed by the inspector.