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
Apr 27, 2022	2022_673672_0009	001919-22	Complaint

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
7070 Derrycrest Drive Mississauga ON L5W 0G5

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

JENNIFER BATTEN (672), NICOLE LEMIEUX (721709)

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): March 23, 24, 25, 28, 29, 30, 31 and April 1, 2022

A Follow-Up inspection (inspection #2022_673672_0007) and a Critical Incident System inspection (inspection #2022_673672_0008) were conducted concurrent to this inspection and findings of non-compliance were issued within those reports.

The following intakes were completed during this inspection:

One intake related to six complaints received by the Director from a resident's Substitute Decision Maker regarding medication administration practices and physician oversight in the home, the resident's hospitalization and change in condition, nutrition and hydration and skin and wound care concerns.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Associate Directors of Care, IPAC Lead, Behavioural Support Ontario Lead (BSO RPN), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Providers (PCPs), Nursing Unit Clerk, Physiotherapists (PT) and physio assistants (PTA), Housekeepers, screeners, students and residents.

The inspector(s) reviewed clinical health records of identified residents, internal policies related to Infection Prevention and Control, Skin and Wound Care, Nutrition and Hydration and Medication Administration. The Inspector(s) also observed staff to resident and resident to resident care and interactions and infection control practices in the home.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Skin and Wound Care

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	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 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

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 resident #031, who was exhibiting altered skin integrity, received a skin assessment by a member of the registered nursing staff upon any return from hospital.

A multifaceted complaint was received by the Director from resident #031's SDM. One of the concerns outlined was related to a skin and wound issue the resident was experiencing, which led to the resident being transferred to hospital for further assessment.

Record review indicated resident #031 was noted to have an area of altered skin integrity following an identified treatment. Resident #031 received further care and a treatment order, as the area was noted to be infected, was later transferred and admitted to hospital for further assessment and treatment of the infection and returned to the home the following day. Review of resident #031's electronic and physical health care record did not indicate any skin and wound assessment had been completed following resident #031's return from hospital.

During an interview, the Administrator verified a skin and wound assessment should have been completed upon resident #031's return from hospital, and that none had been completed as required.

By not ensuring a skin and wound assessment was completed upon resident #031's return from hospital, there was increased risk to the resident related to altered skin integrity. This could lead to the area worsening and/or becoming infected, due to lack of assessment and/or treatment.

Sources: Complaints received from resident #031's SDM; resident #031's progress notes and assessments completed in PCC during a specified period of time; review of resident #031's electronic and physical health care record; interviews with resident #031's SDM and the Administrator. [s. 50. (2) (a) (ii)]

2. The licensee has failed to ensure that resident #031, who was exhibiting altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff.

A multifaceted complaint was received by the Director from resident #031's SDM. One of the concerns outlined was related to a skin and wound issue the resident was experiencing, which led to the resident being transferred to hospital, as the SDM was concerned about the area.

Record review indicated resident #031 was noted to have an area of altered skin integrity following an identified treatment. Resident #031 received further care and a treatment order, as the area was noted to be infected, was later transferred and admitted to hospital for further assessment and treatment of the infection and returned to the home the following day. Review of resident #031's electronic and physical health care record did not indicate any skin and wound assessments had been completed for resident #031's area of altered skin integrity during an identified period of time, when the resident was again transferred to hospital and then discharged from the home.

During an interview, the Administrator verified the area of altered skin integrity should have been reassessed at least weekly by a member of the registered nursing staff. The Administrator further verified if the open area was reassessed weekly, it would have been documented via a skin and wound assessment and that none had been completed as required.

By not ensuring the area of altered skin integrity was reassessed at least weekly by a member of the registered nursing staff, the area worsened and became infected, which led to the resident being transferred and admitted to hospital for treatment.

Sources: Complaints received from resident #031's SDM; resident #031's progress notes and assessments completed in PCC during a specified period of time; review of resident #031's electronic and physical health care record; interviews with resident #031's SDM and the Administrator. [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 residents who are exhibiting altered skin integrity receive a skin assessment by a member of the registered nursing staff upon any return from hospital and are reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

Issued on this 27th day of April, 2022

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

Original report signed by the inspector.