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 # / Registre no	Type of Inspection / Genre d'inspection
Feb 16, 2017	2017_405189_0002	031176-16	Resident Quality Inspection

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 Westbury Long Term Care Residence
495 The West Mall ETOBICOKE ON M9C 5S3

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

NICOLE RANGER (189), VERON ASH (535)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): January 17, 18, 19, 20, 23, 24, 25, 26, 2017.

During the course of the inspection, the inspector(s) spoke with Administrator, Co - Director of Care (co-DOC), MDS Co-ordinator, Environmental Service Manager (ESM), Program and Social Services Manager, Registered Dietitian (RD), Infection Prevention and Control Lead, Occupational Therapist (OT), Recreation Aide, Family Council President, Residents' Council Floor representative, Residents' Council Assistant, registered staff, personal care providers (PCP), residents and family members.

During the course of the inspection, the inspectors conducted observations of residents and home areas, staff and resident interactions, provision of care, medication administration, infection prevention and control practises, reviewed clinical health records, minutes of Residents' Council and Family Council meetings, minutes of relevant committee meetings, and relevant policy and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

8 WN(s)
5 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 there is a written plan of care for each resident that sets out the planned care for the resident.

During stage two of the Resident Quality Inspection (RQI), resident #004 triggered for choice lacking. On an identified date, during an interview, resident #004 stated that he/she engages in a particular routine in order to sleep. Observations and staff interviews revealed an awareness of the resident's particular routine.

A review of the resident’s plan of care revealed that the resident’s sleeping routine was not documented in the plan of care. An interview with RN #120 confirmed that the written plan of care for resident #004 did not include the sleeping routine to promote sleep during the night. [s. 6. (1)]

2. 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.

During stage two of the RQI, resident #005 triggered for choice lacking related to personal care. On an identified date, during an interview, the resident stated that the staff got him/her out of bed by an identified time in the morning, but that he/she would rather get out of bed whenever they wake up in the morning. During interviews with PCP #136 and RPN #137, the staff confirmed that sometimes the resident does not want to wake up in the mornings, but would rather sleep in bed later and that staff are aware.

Record review of the plan of care showed that resident #005 likes to get up around at a specific time in the morning, and that he/she was able to make decisions. During separate interviews, PCP #136 and RPN #137 acknowledged that the plan of care should be reviewed and revised to reflect the change in the resident’s care needs. [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 there is a written plan of care for each resident that sets out the planned care for the resident, and that 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

During an interview with resident #021's Substitute Decision Maker (SDM), he/she reported that on an identified date, he/she found the resident's medication, on top of the resident's cabinet in his/her bedroom. The medication was intact and not consumed by the resident.

Record review of resident #021's written plan of care instructs the registered staff to ensure that resident #021 swallows all his/her medication at the time of administration, do not leave medication in his/her room/washroom.

Record review of the Medication Administration Record (MAR) noted that resident #021 receives the medication at a specific time.

A review of the home's policy entitled " Medication Administration – LTC-CA-WQ-200-06-01" revised July 2015, directs the registered staff to observe the resident taking all of the medication with water provided – never leave medication at side of bed, on table in dining room, at resident's side – always ensure they take the medication.

Interview with co-DOC #119, revealed that resident #021's SDM brought the medication to him/her on an identified date, and informed that he/she found the medication on top of the resident's cabinet. The co–DOC reported to the inspector that he/she conducted an investigation with the registered staff who worked prior to the identified date, and he/she was not able to determine who left the medication at the bedside. The co-DOC reported that this is not the first ocurrance of medication left in resident's room, and a memo was sent to all staff to ensure the medication administration policy is being adhered to. The co- DOC confirmed that this practice does not follow the home's policy related to medication administration. [s. 8. (1) (b)]

2. On an identified date, during the medication administration observation with RPN #105, the inspector reviewed the narcotic and controlled substance count and noted the following discrepancies:

1. Resident #014 - identified medication - balance in the narcotic bin was two, balance on the narcotic and controlled substances record was three.
2. Resident #015 - identified medication - balance in the narcotic bin was four, narcotic and controlled substances record was five.
3. Resident #016 - identified medication - balance in the narcotic bin was four, narcotic and controlled substances record was five.
4. Resident #017 - identified medication - balance in the narcotic bin was two, narcotic and controlled substances record was three.
5. Resident #018 - identified medication - balance in the narcotic bin was six, narcotic and controlled substances record was seven.
6. Resident #019 - identified medication - balance in the narcotic bin was five, narcotic and controlled substances record was four.

Record review of the home's Pharmacy and Therapeutics Narcotics Policy Number LTC-CA-WQ-200-06-14, dated May 2012 with revision December 2016, showed that registered staff must document each time a narcotic and controlled substance was

administered to the resident.

During an interview with RPN #105, he/she confirmed that he/she administered one tablet to each resident earlier in the shift but did not document the removal on the narcotic and controlled substances record at the time the medication was administered. RPN #105 confirmed that he/she did not comply with the home's narcotic administration policy. [s. 8. (1) (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 any policy related to medication administration and narcotics and controlled substance is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system was on at all times.

On an identified date, while conducting stage one of the RQI, testing of the resident-staff communication and response system revealed the following issues: activation of resident #020's call bell in the washroom displayed no light outside the room door and the personal care provider (PCP) pager was not activated. The inspector activated the call bell in resident #020's room, after six minutes, there was no staff response to the call bell. The inspector went to seek the staff. Interviews with PCP #129 , PCP #116, and RN #115 acknowledged that the call bell light was not functional; and that both PCPs pagers were not functional at the time of testing. Activation of resident #032's call bell revealed that PCP #132, who was covering the unit, carried a pager which had the audible function and vibrating function disabled. Activation of the pager resulted in a small red light flashing, however the pager was in the PCP's pocket and therefore activation was not seen by staff.

During an interview, the Environmental Service Manager #113 stated that although the incidents were not formally documented, during night audits, he/she observed that staff working on the night shift often turn off, silence or set the pagers to vibrate. The ESM further stated that there was an audit process in place to check and ensure that the call bell system and pagers were kept in working condition; however there were no process in place for checking staff pagers randomly during all shifts to ensure that the pagers were turned on by staff.

During an interview, resident #012, he/she stated that on an identified date, he/she sustained a self-inflicted injury. The resident rang the call bell in the bedroom and when no staff responded, he/she went into the washroom and rang that call bell, however no staff responded. The resident stated that he/she walked slowly out to the nursing station where the nurse was located and the resident was subsequently assessed by the nurse and sent to hospital for treatment. Record review confirmed that the incident was documented in the progress notes.

During an interview, the ESM stated that the expectation was for the PCP to check their pagers and ensure they were functional at the beginning of each shift; and that pagers were kept in the audible setting so that the resident-staff response system was on at all times. [s. 17. (1) (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 the home is equipped with a resident-staff communication and response system that is on at all times, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the residents protected from abuse by anyone and free from neglect by the licensee or staff in the home.e.

On an identified date, the inspector was standing by the nursing station and observed the fire doors were closed. The inspector observed recreation staff #130 open and walked through the fire doors, then turned around and spoke to resident #011 in a strong tone while stating "I can't open every door for you". The inspector observed resident #011 walking behind recreation staff #130.

During an interview with Resident #011, he/she stated that he/she could not clearly recall the incident, but added that the staff was having a busy afternoon. During an interview with the recreation staff #130 , he/she confirmed that his/her statement to the resident was definitely "over the top". The recreation staff continued to say that the resident had earlier requested that the recreation staff do more for him/her than what was in his/her job description. During an interview with the program and social services manager #112, he/she stated that the expectation was that recreation staff treat all residents with respect and speak to them in a respectful manner and that staff must not communicate with

residents in a degrading or demeaning manner. [s. 19. (1)]

2. During an interview with the family council president, they identified an incident where resident #021 did not receive assistance from staff in a timely manner. Interview with resident #021's Substitute Decision Maker (SDM) revealed that on an identified date and time, he/she received a voice message from resident #021 stating that he/she had fallen and required assistance. The SDM reported that he/she retrieved the message and called the home to inform the staff about the incident. The SDM reported that he/she spoke with RN #122 and informed him/her about the message he/she received from the resident. RN #122 reported to the inspector that he/she was located on the lower level floor of the home when he/she received the call from resident #021's SDM, so he/she went upstairs to the resident's unit to assess the situation. RN #122 reported to the inspector upon arrival to the unit, he/she observed PCP #121 sitting in the care conference room located in the nursing station. RN #122 reported that he/she went into the resident's room and found resident #021 lying on the floor beside his/her bed. RN #122 reported that he/she called PCP #121 to come and assist and called RN #128, who is in charge of the unit, to come down to assist. Both RN #122 and RN #128 assessed the resident for injury, and placed the resident back into bed.

Interview with PCP #121 revealed that resident #021 called for assistance to be taken to the washroom. PCP #121 reported that he/she assisted the resident to washroom, then went into the shower room and proceeded to clean the residents' wheelchairs that were scheduled to be cleaned. PCP #121 reported after cleaning the wheelchairs and the shower room, he/she returned to the nursing station. PCP #121 reported that he/she did not go back to check on the resident when he/she was on the toilet as the resident will on occasion refuse assistance. PCP #121 reported he/she was not aware that resident #021 had fallen until RN #122 came on the unit.

Review of resident #021's written plan of care indicated that resident #021 requires assistance with toileting, staff to provide privacy and check on resident on a regular basis to prevent falls. Resident #021 is high risk for falls.

Interview with RN #122 and RN #128 reported that the expectation for PCP staff who assist the resident to the toilet, is to stay nearby or frequently check on the resident to ensure the resident is safe in the washroom. Both RN #122 and RN #128 reported that PCP #121 did not assist the resident with his/her toileting needs. Interview with the co - DOC #118 confirmed that the resident was left unattended, had fallen in his/her room, and did not receive assistance for approximately 30 minutes. The co-DOC confirmed that

the PCP are expected to assist the resident with their toileting needs, and that PCP #121 did not assist resident #021 with his/her toileting needs. [s. 19. (1)]

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 the home protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident’s hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

During stage two of the RQI, resident #004 triggered for not receiving personal care as per his/her choice.

Record review of the written plan of care for resident #004's showed that the resident is scheduled to have a bath once per week and a shower once per week. On an identified date, during an interview, the resident informed the inspector that he/she received a shower only once every two or three weeks, and that he/she would like to have one shower and one bath each week. The resident also stated that he/she would like to have the shower at an identified time. During an interview, the resident's primary PCP #107, the PCP stated that sometimes the resident refused the shower stating that he/she was cold; therefore, the PCP provided an alternative instead of taking the resident for a shower. The PCP also confirmed that he/she had not taken the resident for a shower for the four weeks since he/she had taken over the resident's care. During an interview, RN #120 stated that he/she had never seen the resident taken for a shower, therefore the resident must have received a bathing alternative. The registered staff also stated that he/she always documented in the progress notes when a resident refused to be showered, and that the PCP did not report to him/her that resident #004 had been refusing to be showered. A review of the resident's progress notes revealed no documentation of the resident's refusal to shower for the previous three weeks. RN #120 confirmed that resident #004 was not being bathed by his/her method of choice. [s. 33. (1)]

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 each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to have his or her participation in decision-making respected.

During stage two of the RQI, resident #005 triggered for choice lacking related to personal care. On an identified date, during an interview, the resident stated that he/she was provided a shower twice each week during the evening, but he/she would rather have a shower in the morning. During interviews PCP #136 and registered staff RPN #137 both stated that residents were not asked if they want to be showered in the morning or evening when they were admitted to the home.

Record review of the resident's plan of care indicate that he/she was able to make decisions. The plan of care also showed that the resident's preference was for a shower, but did not indicate a time of day preference to have the shower. During separate interviews, PCP #136 and RPN #137 acknowledged that staff did not fully respect and promote the resident's right to participate in decision-making. [s. 3. (1) 9.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and locked when they were not being supervised by staff.

On an identified date, during the initial tour of the home, the following doors were observed to be unlocked and these non-residential areas accessible to residents: an identified floor linen closet which was equipped with locked doors. PCP #133 and RN #134 confirmed that the linen closet doors should have been locked, but that the lock was broken. An identified floor linen closet was left unlocked and RPN #135 confirmed that the doors should have been locked. An identified floor Tidy Cupboard with housekeeping supplies, was unlocked and RPN #135 confirmed that the door should have been locked. [s. 9. (1) 2.]

WN #8: 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 staff participated in the implementation of the infection prevention and control program.

On an identified date, while performing medication administration for resident #014, the inspector observed RPN #105 did not perform hand hygiene prior to administering medication to the resident. RPN #105 removed the blister package from the narcotic bin and poured the half tablet from the controlled substance package into his/her hand before transferring the half tablet into the paper cup for administration to the resident. During an interview, the RPN acknowledged that he/she did not perform hand hygiene prior to medication administration. During an interview with the home’s Infection Prevention and Controlled coordinator #108, he/she stated that when administering medication, registered staff should perform hand hygiene between residents by using hand sanitizer if hands were not soiled; and if hands were soiled, staff should wash with soap and water. [s. 229. (4)]

Issued on this 21st day of February, 2017

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

Original report signed by the inspector.