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
Nov 2, 2016	2016_363659_0030	029432-16	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 Westmount Long Term Care Residence
200 David Bergey Drive KITCHENER ON N2E 3Y4

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

JANETM EVANS (659), NUZHAT UDDIN (532)

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): October 13, 14, 14, 18, 19, 20 and 21, 2016

The following intakes were completed as part of this RQI: Critical Incident Log # 027978-16-2880-000014-16 for a reported fall with fractured right hip and Critical Incident Log # 030687-16-2880-000017-16 for an alleged abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Clinical Service, the Director of Care, the Business Manager, the Social Worker, the Program Support Services Manager, the Environmental Service Manager, the RAI Coordinator, the PSW Coordinator, Registered Nurses, Registered Practical Nurses, Personal Care Providers, the Physical Therapy Assistant, Maintenance staff, the Resident Council President; Family Council Representative and residents and family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
4 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	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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Initial review of plan of care indicated that the resident used a bed rail while in bed.

An initial observation made were that two rails had been raised on the resident's bed. A second observation of the resident revealed that both bed rails were down.

The Power Of Attorney (POA) was informed about the risk of bed rails it was recommended to take both rails down; they stated that they did not agree with it but did not think they had a choice.

Plan of care was reviewed and had been revised to indicate that the resident no longer used bed rails.

Director of Clinical Service (DOCS) stated that they would clarify and review the expectations with staff and update the plan of care so it provided clear directions to staff and others who provided direct care to the resident.

The scope of this area of non-compliance was determined to be 1 isolated, the severity was a level 2 potential for harm and there was previous history of related non-compliance. [s. 6. (1) (c)]

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 plan of care set out clear directions to staff and others who provide direct care to the resident, 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 of the home failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Record review and bed rail assessment stated that resident # 002 has the right bed rail (the one against the wall) up while in bed as a Personal Assistive Service Device (PASD).

On a number of room and bed observations it was revealed that when moved, the bed rail was loose and stayed in the outward position creating a gap between the mattress and the quarter rail.

Environmental Services Manager #127 (ESM) observed the bed rails, with Inspector # 532, and confirmed that the rail was loose creating a gap between the bed and the mattress.

The ESM acknowledged that the licensee's policy was not followed when the bed rail became loose and created a gap between a mattress and bed rail and potentially causing a risk for entrapment for the resident.

The scope of this area of non-compliance was determined to be 1 isolated; the severity was a level 2 potential for harm and there was no previous related history non-compliance. [s. 8. (1)]

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

The RN assessed the identified resident post fall and did not see obvious injury however the resident complained of pain post fall. The RN documented the fall on the day of its occurrence but did not follow procedure for the documentation related to notification of the physician of the resident's fall.

The physician was not notified of the fall until three days after the fall occurred at which time the resident was transferred to hospital for assessment.

The Director of Clinical Services acknowledged that the physician should have been notified post resident's fall.

The scope of this area of non-compliance was determined to be 1 isolated; the severity was a level 2 potential for harm ; there was no previously related history of non-compliance. [s. 8. (1) (a),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 plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to safety risks - specifically risk of falls.

A post fall analysis was completed for an identified resident and recommendations from this were made related to the implementation of safety devices for the identified resident.

The identified resident's plan of care did not include the use use of the safety devices.

The Director of Clinical Services (DOCS) said that when she looked at the care plan it did not reflect the care resident #010 should have had in place. The DOCS said that the expectation was that the recommendations made for the use of the safety devices should have been documented in the resident's plan of care and implemented.

The scope of this area of non-compliance was determined to be1 isolated, the severity was a level 2 - potential for harm and there was no previously related history of non-compliance. [s. 26. (3) 19.]

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 plan of care is based on an interdisciplinary assessment with respect to safety risks - specifically risk of falls, to be implemented voluntarily.

WN #4: 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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Record review for an identified resident indicated that the resident had impaired skin integrity.

Plan of care for the identified resident indicated that the resident had altered skin integrity. Interventions included weekly assessment and assistive device.

No assistive device was in place for the identified resident.

The Co-Director of Care stated that the identified resident should have had assistive devices in place.

The scope of this area of non-compliance was determined to be 1 isolated, the severity was a level 2 - potential for harm and there was no previously related history of non-compliance. [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 to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, to be implemented voluntarily.

Issued on this 2nd day of November, 2016

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

Original report signed by the inspector.