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
Dec 19, 2019	2019_798738_0024	020239-19, 021837-19	Complaint

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

Long-Term Care Home/Foyer de soins de longue durée

Chartwell Elmira Long Term Care Residence
11 Herbert Street Elmira ON N3B 2B8

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

AMANDA OWEN (738)

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): December 6, 10, 11, 13 and 16, 2019.

The following intake was completed in this Complaint inspection: Log #021837-19, related to resident care concerns.

The following Critical Incident System (CIS) intake was also completed in this Complaint inspection: Log #020239-19/CIS #2471-000006-19, related to resident care concerns.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Dietary Manager, Dietician, Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

The inspector(s) also toured resident home areas, observed resident care provision, resident to staff interaction, reviewed relevant residents' clinical records and interviewed staff and residents.

The following Inspection Protocols were used during this inspection:
Dining Observation
Nutrition and Hydration
Personal Support Services
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure the resident's substitute decision maker (SDM) and any other persons designated by the resident or SDM were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A) On a specified date, resident #001 was identified to have altered skin integrity on a specified area. The resident's SDM and any other persons designated by the resident or SDM were not notified about the altered skin integrity until several weeks after it was identified.

B) On a specified date, resident #001's altered skin integrity was identified to have worsened. The resident's SDM and any other persons designated by the resident or SDM were not notified about the worsened altered skin integrity until eleven days after it was identified.

RPN/RAI Coordinator #112 and RN #111 stated that the resident's SDM and any other persons designated by the resident or SDM should be notified immediately of any new or worsening skin conditions identified on a resident.

The licensee failed to ensure that resident #001's SDM and any other persons designated by the resident or SDM were given an opportunity to participate fully in the development and implementation of the resident's plan of care. [s. 6. (5)]

2. The licensee failed to ensure that the provision of care set out in the plan of care was documented.

Clinical records showed that residents #001, #002 and #003 required assistance with two specified activities of daily living (ADL).

A documentation survey report was reviewed for each of the residents in relation to these ADLs. It documented that one of the specified ADLs did not occur for each of the residents on multiple dates, despite their being conflicting documentation.

The report failed to document if this specified ADL was provided to each of the residents on multiple dates.

The report also failed to document if the other ADL was provided to each of these residents on multiple dates.

RPN #104, PSW #105 and PSW #106 believed staff were assisting residents with the specified ADLs as required, but were not documenting it correctly.

RPN #104 said staff were confused on how to document one of the specified ADLs.

The licensee failed to ensure that the provision of care set out in the plan of care was documented for residents #001, #002 and #003. [s. 6. (9) 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 provision of the care set out in the plan of care is documented for residents #001, #002, #003 and any other resident, 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 failed to ensure that resident #001 received immediate treatment and interventions to promote healing and prevent infection of their altered skin integrity.

A weekly skin assessment showed that on a specified date, resident #001 was identified to have altered skin integrity with signs and symptoms of an infection.

Records showed the physician was not notified about the condition of the altered skin integrity until several days after it was identified to have signs and symptoms of an infection. At that time, the physician prescribed medications and treatment for the altered skin integrity to address the potential infection.

Test results showed the altered skin integrity was infected.

RPN/RAI Coordinator #112 and RN #111 said that a physician would be notified immediately if a resident's altered skin integrity was suspected to be infected.

RPN/RAI Coordinator #112 said the resident's altered skin integrity displayed signs and symptoms of an infection. They said the physician should have been notified about the altered skin integrity earlier.

The licensee failed to ensure that resident #001 received immediate treatment and interventions to promote healing and prevent infection of their altered skin integrity. [s. 50. (2) (b) (ii)]

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

RN #111 stated that resident #007 was identified to have altered skin integrity on a specified area.

Assessments related to the altered skin integrity were reviewed and showed the area was not reassessed at least weekly on multiple dates over a specified period of time.

RN #111 said that resident #007's altered skin integrity should have been reassessed weekly but staff failed to do this on several occasions.

The licensee failed to ensure that resident #007’s altered skin integrity 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 resident #001 and any other resident exhibiting altered skin integrity receives immediate treatment and interventions to promote healing and prevent infection, to be implemented voluntarily.

Issued on this 16th day of January, 2020

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

Original report signed by the inspector.