Ontario

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
Jul 20, 2017	2017_543561_0009	008749-17	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 Wenleigh Long Term Care Residence
2065 Leanne Boulevard MISSISSAUGA ON L5K 2L6

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

DARIA TRZOS (561)

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): June 29, 30, 2017 and July 4, 5 and 6, 2017.

Complaint Inspection log number 008749-17

During the course of the inspection, the inspector(s) spoke with the Administrator, Clinical Director of Care (CDOC), Assistant Director of Care (ADOC), Food Service Manager, Registered Dietitian (RD), Physiotherapist, Wound Care Nurse, Registered staff, Personal Support Workers (PSWs), family and residents.

During the course of the inspection, the inspectors observed provision of care, observed meal services, reviewed health care records and policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 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).

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 failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

Resident #001 was considered at risk for falls as per the plan of care. A concern was identified that the staff were not implementing an intervention to prevent falls which placed the resident at risk. Resident was observed during inspection while they were in bed and the intervention was implemented. The interview with PSW #106 confirmed that this particular intervention was in place for resident.
The ADOC, the lead for the Falls Program was interviewed and confirmed that the resident was at risk for falls and that the intervention in question was being implemented for the resident. The current written plan of care was reviewed and this intervention was not included in the written plan of care.

The licensee failed to ensure that the written plan of care set out the planned care for resident #001 in relation to the falls intervention. [s. 6. (1) (a)]

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

A) Resident #001 had a plan of care indicating that they were at a nutritional risk due to their health condition. Certain interventions were in place for resident addressing this risk. Interview with PSW #118 and registered staff #100 indicated that during snacks resident was not to be left unattended and unsupervised.
During the observation of the resident's room, it was observed that one of the

interventions was not followed. The registered staff indicated that at daily reports they reminded staff about this intervention.
The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

B) Resident #001 had a plan of care indicating that resident required a certain level of assistance for toileting.
Interviewed PSW # 113 and stated that on a day shift on an identified date, they had provided care for resident by themselves. The PSW was aware of the level of assistance required.
Interviewed PSW #116 who provided direct care to the resident on an identified date, and stated that they provided care to resident on their own. The PSW stated that resident needed assistance; however there was no staff available on the unit at that time.
The level of assistance that resident required was confirmed by registered staff #100.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan for the level of assistance. [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 that there is a written plan of care for each resident that sets out the planned care for the resident and to ensure that that 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 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 the "Resident Incident Reports" policy was complied with.

In accordance with Regulation, s.48, required the licensee to ensure that the interdisciplinary programs including a skin and wound care program were developed and implemented in the home and each program must, in addition to meeting the requirements set out in section 30, provide for screening protocols; and provide for assessment and reassessment instruments. O. Reg. 79/10, s.48

The home's policy titled "Resident Incident Reports", policy number LTC-CA-WQ-200-07-09, revised on November 2014, indicated that "an incident report was to be completed following any incident occurring in the home in PCC using the risk management module for the incident, and the DOC and the Administrator must be notified to review the incident report. All skin abrasions or bruises of unknown origin, noticed by staff are all considered incidents and must be documented as such".

Resident #001 sustained altered skin integrity that was first noticed by the registered staff #108 on an identified day in 2017. The health care record review indicated that the registered staff did assess the resident and notified the Substitute Decision Maker (SDM) of the skin issue; however did not complete the incident report through the risk management so that it would alert the management to start an investigation to the unknown cause of the skin alteration. Interview with the registered staff #108 confirmed that the PSW staff did not report any new skin issues to them on their shift and the previous shift did not report any new incidents at end of shift. Registered staff #108 stated that it was an expectation of the PSW staff to report any new alteration of skin integrity to registered staff. Registered staff confirmed that they did not complete the risk

management report.

The PSW #113 that worked on the shift that the new skin alteration was observed stated that they were not regular staff on the floor and this is why they did not report it to the registered staff.

The interview with CDOC #001 confirmed that any new alteration in skin integrity were to be reported to registered staff by PSWs and the risk management reported was required to be completed so that the home could initiate an investigation. This was not done for this resident.

The licensee failed to ensure that their policy for Resident Incident Reports was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that the "Order/Re-ordering/Destruction of Drugs; Drug Record Book " policy was complied with.

The Long Term Care Homes Act, 2007, Ontario Regulation 79/10, regulation 136 (2) stated that the drug destruction and disposal policy must provide that the drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs.

The home's policy titled "Order/Re-ordering/Destruction of Drugs; Drug Record Book", policy number LTC-CA-WQ-200-06-16, indicated that medications for destruction are to be placed in the designated container for bio-hazardous waste with an identification or other such feature that prevents the removal of the medication and stored separately from drugs available for administration".

On June 29, 2017, LTC Inspector observed a prescription cream in resident #001's bathroom. The label on the cream indicated that the cream was to be applied on an identified date in 2016 for only a number of days. PSW #103 was interviewed and could not recall if the cream was being applied recently; however did say that it should not have been left in resident's bathroom. Interview with the registered staff #100 confirmed that the cream should have been disposed of as per the direction by the physician and should not have been sitting in resident's room.
The CDOC was interviewed and confirmed that the prescription cream should have been disposed of after the order was discontinued.

The licensee failed to ensure that their Drug Destruction policy was complied with. [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. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Resident #001's recent Minimum Data Set (MDS) quarterly assessment, indicated that there was an an improvement in resident's level of bladder incontinence and a deterioration in the level of bowel incontinence.

The health care records were reviewed and indicated that there was no bladder or bowel continence assessment completed and no new interventions implemented to address the change after the MDS assessment.
PSW #103 confirmed the level of bladder incontinence as indicated in the MDS assessment.
Interview with the registered staff #100 indicated that a comprehensive assessment for continence was to be completed when there was a change in resident's continence.

The interview with the CDOC confirmed that it was an expectation when there was a change in continence staff were expected to complete either bowel or bladder continence assessment in Point Click Care (PCC) and confirmed that this was not done for resident #001.

The home's policy titled "Continence Care", policy number LTC-CA-WQ-200-02-05, revised January 2016, indicated that when there was a significant change in resident's status, either with bowel or bladder continence level, this change will further be assessed using the appropriate Continence Assessment in PCC.

The licensee failed to ensure that resident was assessed using a clinically appropriate assessment instrument designed for assessment of incontinence when there was a change in resident's incontinence. [s. 51. (2) (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 resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administered a drug to himself or herself unless the administration had been approved by the prescriber in consultation with the resident.

On July 4, 2017, LTC Inspector observed prescribed drugs in resident #001's room. The registered staff #100 was called to the room and indicated that resident was applying the drugs by themselves and the drugs were provided by the family. Resident was later interviewed and indicated that they kept the drugs with them by their side.
Resident's health care records were reviewed and there was no physician order for the drugs. The health care records indicated that the drugs were discontinued prior to this observation.

The registered staff #100 was interviewed and indicated that this order was discontinued at one point and that they will clarify with family if resident still required the drugs and will call the physician to obtain a new order.
The Administrator confirmed that they were required to obtain a physician order.

The licensee failed to ensure that no resident administered drugs to themselves unless the administration had been approved by the prescriber. [s. 131. (5)]

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 no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident and to ensure that no resident who is permitted to administer a drug to himself or herself keeps the drug on his or her person or in his or her room except as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #001 had a plan of care indicating that they had alteration skin integrity. One of the interventions to promote healing and further skin breakdown was to reposition resident every two hours.
PSWs and registered staff were interviewed during the inspection and confirmed that this was an intervention to promote wound healing and PSWs were required to document in Point of Care (POC) that they provided this intervention. POC was reviewed for several months in 2017 and there was no documentation indicating that every two hours repositioning was always done.
The interview with the CDOC confirmed that the staff were expected to document the care provided in POC.

The licensee failed to ensure that the documentation for repositioning every two hours was always completed. [s. 30. (2)]

WN #6: 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 had been assessed by a registered dietitian who is a member of the staff of the home.

Resident #001 sustained an alteration in skin integrity as per the progress note documented on an identified day in 2017. Registered staff #108 was interviewed during inspection and indicated that the skin alteration was not reported to them by any staff member when they came on their shift. They had observed it on their shift and assessed the resident and notified the resident's SDM. The health care records and interview with the registered staff #108 indicated that the referral to the Registered Dietitian was not completed. The Registered Dietitian was interviewed and confirmed that they were not aware of the resident's new skin issue and they did not receive the referral after the alteration of skin integrity was observed on an identified day in 2017.

The home's policy titled "Wound Care Treatment", policy number LTC-CA-WQ-200-08-03, revised November 2014 indicated that resident exhibiting altered skin integrity will receive a skin assessment, immediate treatment and a referral to the Registered Dietitian".

The CDOC #001 confirmed that the staff should have referred the resident to the Registered Dietitian when they became aware of the skin alteration.

The licensee failed to ensure that resident #001 was assessed by the Registered Dietitian when they sustained an alteration in skin integrity. [s. 50. (2) (b) (iii)]

Issued on this 31st day of July, 2017

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

Original report signed by the inspector.