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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Public Copy/Copie du rapport public

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_792659_0025	017652-19, 018036-19, 021595-19	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 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)

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): November 19, 20, 21, 22, 25, 26, 27 and 28, 2019.

Log #017652-19, IL-70151-CW, Complaint related to falls with injury.
Log #018036-19, Critical Incident (CI) 2880-000022-19 related to fall with injury.
Log #021595-19, IL-71902-CW, Complaint related to resident care.

During the course of the inspection, the inspector(s) spoke with the Administrator, co-Directors of care (co-DOC), Registered Nurses (RN), RN Student, Business Manager, Registered Practical Nurses (RPN), Person Care Providers (PCP), Dietary Aide and residents.

Observations were made of medication administration, provision of care, staff to resident interactions. A review of relevant records was completed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Medication
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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. 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007,

c. 8, s. 3 (1).
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).
20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an identified resident's right to participate in decision making was respected and that their personal health information was kept confidential.

Complaints were received by the MLTC and the nursing home related to an identified resident's care.

In April 2019, a capacity evaluation for long term care home placement was completed by the Waterloo-Wellington Local Health Integration Network (LHIN). The assessor documented that for the purpose of the assessment, the resident was deemed capable. The identified resident appointed a person as their designate to communicate with the LHIN on their behalf, related to the long term care home (LTCH) admission.

There were no documented Power of Attorney (POA)/ Substitute Decision Maker (SDM) papers found in the identified resident's records.

The identified resident sustained three falls within a specified period and was assessed at hospital as having sustained an injury. The next of kin was notified and began making care decisions for the resident in hospital and upon the resident's return to the home.

The clinical record documented numerous communications between the next of kin the nursing home where the home was advised that the resident was not to be given any specified medications.

A nurse assessed the resident to have some short term memory loss, but they had sufficient understanding to make decisions for themselves.

One co-DOC said they failed the identified resident when they allowed the next of kin to make decisions for them without ensuring they were the SDM. Normally they would not

allow the next of kin to make decisions for a resident if they were not the SDM.

The Administrator said the next of kin would not sign provided documents for POA/SDM and there was no documented POA/SDM when the resident died. The Administrator said they were told the identified resident was deemed incapable of making medical decisions, but the next of kin could not provide any documentation related to this. The Administrator said that normally they would take direction from the resident. The Administrator said they were involved with their corporate office to try to get a capacity assessment completed so they could have documentation and support the identified resident.

The licensee failed to ensure that the identified resident's right to participate in decision making was respected and that their personal health information was kept confidential. [s. 3. (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 all resident's rights to participate in decision making is respected and that all resident's personal health information is kept confidential, to be implemented voluntarily.

WN #2: 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. (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).

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 has failed to ensure that care set out in the plan of care with respect to safety checks and bed alarms for an identified resident, was provided to the resident as specified in the plan.

A complaint was made to the home and to the MLTC related to falls prevention for an identified resident, sustained within a two week period.

The identified resident had a history of falls and the clinical record documented seven unwitnessed falls within a four month period.

The care plan prior to these falls documented the resident required cuing to use their assistive device. The plan of care was updated with subsequent falls to include use of a safety device and monitoring for specified timeframes and other fall prevention strategies.

Review of the clinical records showed documentation that the resident did not have a safety device in place at the time of two falls.

Staff said that the resident was at risk for falls as they tried to self transfer out of bed. Frequent monitoring along with the use of safety devices had been implemented for the resident. Staff and the co-DOCs said safety checks were to be documented. A co-DOC stated that timed safety checks were of short duration and would be completed for 24 to 48 hours post fall. The completed record was to be placed in the resident's chart.

A RPN and co-DOC reviewed the identified resident 's chart for safety checks and acknowledged that there were no documented safety check sheets for the resident for a specified three day period. The RPN said they had not monitored the identified resident as they should have.

A co-DOC said that the identified resident was known to remove their safety device and staff needed to be diligent to ensure that it was put back in place.

The licensee failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan; specifically related to the completion of safety checks and ensuring the safety device was in place for the identified resident. [s. 6. (7)]

2. The licensee has failed to ensure that the nutrition and fluid intake for three identified residents was consistently documented.

A complaint was received to the MLTC related to nutritional/fluid intake and low blood sugars for a resident.

Two of the identified residents were assessed to be at high nutritional risk and had experienced weight loss; the third resident was documented as moderate nutritional risk and had fluctuating blood sugars.

Review of the look back report specific to nutrition and fluid intake for a specified two week timeframe for nourishment, meal intake, special snacks and fluid intake, showed anywhere from 4 blanks to 19 blanks in the documentation for each of the residents intake.

Three PCP said whoever cleared a resident's plate away would document the resident's intake it into the computer. One PCP said leaving blanks in the documentation was not an option. If someone did not come for a meal they should write not applicable (na) or resident not available (nv).

A RPN and a RN reviewed the food and fluid intake documentation for a resident and acknowledged blanks were left in the documentation. The RPN said it was a huge problem that some of the PCPs didn't document the resident's intake. The RPN said that a blank in this documentation could mean a resident did not eat, but it would be difficult to interpret each instance.

The licensee failed to ensure that the following were documented: the provision of the care set out in the plan of care, specifically the licensee has failed to ensure that the nutrition and fluid intake was consistently documented for the three identified residents. [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 staff follow the plan of care for all resident's with respect to fall interventions and monitoring and that the provision of care for all residents, specifically, nutritional and fluid intake for all meals,nourishment and special snack food are documented, to be implemented voluntarily.

WN #3: 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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put any procedure in place, the procedure was complied with.

In accordance with O. Reg. 79/10, s. 49.(1) and in reference s. 48.(1) 1, the licensee was required to have a Falls Prevention and Management Program developed and implemented which included monitoring of residents.

Specifically, staff did not comply with the licensee's “Falls Prevention” policy #LTC-CA-WQ-200-07-08, revised June 2019 as part of their Falls Prevention and Management procedure which said a head injury routine (HIR)/neurological assessment was to be initiated for 48 hours in the case of a suspected head injury or unwitnessed fall, unless otherwise directed by the attending physician.

A complaint was received to the Ministry of Long Term Care (MLTC) related to falls for an identified resident.

The resident had a history of falls and the clinical records for a four month period documented they had seven unwitnessed falls. For these falls there were only two HIR completed. In two instances it was documented the resident denied hitting their head. In three instances staff documented the fall was unwitnessed. There was no documentation in the clinical record that staff received direction from the resident's physician that a HIR was not required.

Two RPN and a co- DOC said if a fall was unwitnessed they were to complete a head injury routine (HIR). A RPN and co- DOC said that if the resident could verbalize they did not hit their head, a HIR was not required.

A RPN acknowledged a HIR had not been completed for one of the identified resident's unwitnessed falls.

The co-DOC acknowledged that there had only been two HIR completed for resident despite there being unwitnessed falls and falls where the resident struck their head.

The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put any procedure in place, the procedure was complied with, specific to documenting HIR for the identified resident's unwitnessed falls. [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 the home's policy related to HIR is complied with, to be implemented voluntarily.

Issued on this 20th day of December, 2019

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

Original report signed by the inspector.