Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District
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Original Public Report

Report Issue Date: May 23, 2023	
Inspection Number: 2023-1365-0006	
Inspection Type: Complaint and Critical Incident System	
Licensee: Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc.	
Long Term Care Home and City: Chartwell Westmount Long Term Care Residence, Kitchener	
Lead Inspector Kristen Owen (741123)	**Inspector Digital Signature** Kristen A Owen Digitally signed by Kristen A Owen Date: 2023.05.24 15:32:45 -04'00'
Additional Inspector(s) Janet Evans (659) Mark Molina (000684) Alicia Campbell (741126)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 1-5, 2023, and May 9, 2023.

The following intakes were completed in this Critical Incident (CI) and complaint inspection:

- Intake 00021212 and intake 00084029 related to alleged improper care and neglect of a resident.

NOTE: A Written Notification related to O. Reg 246/22, s. 54 (1) was identified in a concurrent inspection #2023_1365_0005 (Intake: 00018152) and issued in this report.

The following **Inspection Protocols** were used during this inspection:

Continence Care
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)

The licensee failed to ensure the falls prevention and management program included monitoring of resident's #003 and #002.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure the falls prevention and management program, at a minimum, includes strategies to monitor residents, and must be complied with.

Specifically, staff did not comply with the policy "Resident Falls Prevention Program", last revised June 2022, which stated if a resident had an unwitnessed fall, a head injury routine (HIR) would be initiated, and that a resident's fall risk level would be reassessed (using the Scott Fall Risk Assessment) following a fall with serious injury or after multiple falls.

Rationale and Summary
A) i) Resident #003 had an unwitnessed fall. A HIR was not initiated by the RN. Staff confirmed that a HIR was required but was not completed by the RN.

The home's fall prevention and management program included completion of a HIR for any unwitnessed fall for 48 hours.

ii) Resident #002 was documented as a risk for falls. Between January – February 2023, there were several unwitnessed falls documented for the resident. Only one fall in January 2023, identified an injury to the resident. A HIR was not completed for two of the falls from January – February 2023. Staff said they were to complete HIR for unwitnessed falls. They acknowledged that two of the HIRs were not completed but should have been completed for resident #002.

By not completing the HIR after resident #003's and resident #002's unwitnessed falls, there was a risk that they could have had undetected head injuries.

Sources: Resident #003's clinical health records; home's critical incident investigation notes; resident #002's clinical health records; Resident Falls Prevention Program policy, Policy No: LTC-CA-WQ-200-07-

08, last revised June 2022; interviews with staff.

[000684 and 659]

B) As per the home's fall policy, a resident required reassessment using the Scott Fall Risk Assessment if they had a significant change in condition, if they had a fall with serious injury, or if a resident had multiple falls within a six-month period.

Resident #003 had a fall with serious injury and required hospital admission. The resident had more than two falls in January 2023.

Staff said a reassessment using a Scott Fall Risk Assessment for resident #003 was not completed.

By not reassessing resident #003 using the Scott Fall Risk Assessment, the staff may have missed the opportunity to identify any new fall risk factors and new strategies to reduce or mitigate future falls.

Sources: Interviews with staff; resident #003's clinical health records; home's critical incident investigation notes; Falls Prevention Program Policy, Policy No: LTC-CA-WQ-200-07-08, last revised June 2022

[000684]

WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (a)

The licensee failed to ensure that resident #002, who is incontinent, received an assessment that included 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 required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Rationale and Summary
A complaint was submitted to the Ministry of Long-Term Care (MLTC) stating resident #002 had not received assistance with toileting.

Upon admission to the home, resident #002 was assessed using the Resident Assessment Instrument (RAI) Minimum Data Set (MDS) 2.0 as being occasionally incontinent of bladder.

The home's continence care and bowel management program stated that upon admission to the home and with any change in status, the registered staff were to complete a continence assessment which included causal factors, patterns, type of incontinence and potential to restore function with specific interventions. From this, staff were to develop a resident focused plan of care for continence management.

An RPN stated that the resident had not had a bowel or bladder continence assessment completed. Failure to complete the continence assessment for resident #002 limited the home's knowledge of the most appropriate interventions that would assist to promote the resident's continence or potentially restore function.

Sources: Resident #002's clinical health records; continence care and bowel management program LTC-CA-ON-200-02-05, Revised December 2021; interviews with staff

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WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)

The licensee failed to ensure that resident #002's individualized plan of care for continence was implemented.

Rationale and Summary
A complaint was submitted to the MLTC that stated resident #002 had not received assistance with toileting.

Resident #002's plan of care for continence and bowel management directed staff to provide the resident with scheduled toileting. The toileting schedule was not followed, and the resident was found incontinent of urine in their brief and their bed linen was saturated.

The home's investigation documented purposeful rounds had not been completed hourly on the unit and resident #002 had not received assistance to the toilet for several hours.

The PSW assigned to resident #002's care that day, had not been familiar with the unit's assignment of residents and had not known resident #002 was assigned to their care. They acknowledged going into the resident's room but said they had not offered to toilet the resident.

During the home's investigation, the resident's Substitute Decision Makers video surveillance was reviewed and it showed that staff had entered the resident's room several times, but no one had spoken to the resident or offered to toilet them.

Failure to implement the resident's plan of care for continence management/toileting put the resident at potential risk of skin issues, injury if they attempted self-transfer, or infection.

Sources: Resident #002's clinical health records; home's investigation notes; interviews with staff

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WRITTEN NOTIFICATION: Dining and Snack Service

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.

The licensee failed to ensure that resident #002 was provided personal assistance and encouragement required to safely eat as comfortably and independently as possible.

Rationale and Summary
Resident #002 declined to go to the dining room for their dinner. They were reapproached a second time and declined then as well.

Resident #002's plan of care directed staff to provide supervision and intermittent physical assistance for eating.

A PSW said when a resident refuses a meal, they usually save a plate and bring it to the resident after the dining service. They forgot to do this for resident #002, so they told their co-worker to make the resident food and provide the resident with a drink. The home's investigation documented the resident

was provided with food and a drink from the snack cart. Later, a snack and another drink were put in the resident's room. No staff stayed to supervise or assist the resident with eating.

The home's policy for tray service said that meal trays were to be served to residents after the dining service was completed and staff were to monitor the residents as per their plan of care.

Staff said every resident who did not attend the dining room was to be offered tray service and staff were to provide supervision for the meal. Staff said this was not done for resident #002.

Failure to provide supervision and assistance to resident #002 for safe eating may have put the resident at risk of lower nutritional intake or the ability to intervene quickly to any potential choking incidents.

Sources: Complaint intake #0008402, policy tray service, LTC-CA-WQ-300-03-06, Revised Jan 2023, plan of care, home's investigation, interviews with staff

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