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 10, 2017	2017_547591_0010	009288-17	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 Waterford Long Term Care Residence
2140 Baronwood Drive OAKVILLE ON L6M 4V6

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

NATASHA JONES (591), KELLY HAYES (583), SAMANTHA DIPIERO (619)

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): May 23, 24, 25, 26, 29, 30, 31, June 2, 6, 7, 8, 9, and 12, 2017.

The following Complaint Inspections were completed concurrently during this Resident Quality Inspection (RQI):
007452-17 - related to missing medication
007856-17 - related to multiple resident care concerns
008874-17 - related to Resident Rights
002543-17 - equipment and transfers
007531-17 - admissions

The following Critical Incident inspections were completed concurrently during this RQI:
008482-17 - related to Resident rights
008609-17 - staff to resident abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, Directors of Care (DOCs), Resident Assessment Instrument (RAI) Coordinator, Assistant Director of Care (ADOC), Food Services Manager, Nutrition Manager (NM), Environmental Services Manager, Environmental Consultant, Physiotherapist (PT), Registered Dietitian (RD), Registered Nursing Staff, Personal Support Workers (PSWs), Family and Residents' Council representatives, maintenance staff, Dietary Aides, Residents and Residents' family members.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2017_449619_0005	591

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. 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:
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).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident had the right to be afforded privacy in treatment and in caring for his or her personal needs.

Resident #006 had cognitive impairment and no known history of responsive behaviours. A review of the resident's current written plan of care indicated that the resident required assistance from one staff for all activities of daily living. On an identified date in 2017, a Ministry of Health and Long Term Care (MOHLTC) Inspector observed resident #006's room door fully open while passing in the hall and observed the resident to be exposed. On entry, the Inspector observed the resident lying in bed, partially clothed, and the resident was not covered with a blanket. Interview with resident #006 indicated that they had removed the blanket, and were unaware that the door was open. The resident further stated that they felt "undignified and upset" that they were observed in a state of undress and that their privacy was not maintained. In an interview, personal support worker (PSW) #108 indicated that they left the resident in the room partially clothed to await a treatment by the registered staff and could not confirm that the resident's door was shut completely when they exited the room. In an interview, registered staff #100 confirmed that the resident was exposed and that the resident could have been seen by persons from the hallway. In an interview, DOC #1 confirmed that the resident was not provided privacy. [s. 3. (1) 8.]

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 every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control program.

On an identified date in 2017, during the initial tour of the home, a total of three home areas were found to have unlabelled used personal hygiene products or unclean surface areas. In interviews, PSW staff indicated that sometimes residents had episodes of bowel incontinence in the shower room and that staff were responsible for cleaning and disinfecting the area after use. PSW #108 also confirmed that staff were to label all personal hygiene products to prevent cross-contamination. Registered staff #107 confirmed that personal hygiene items should be labelled in accordance with the home's infection prevention and control policy. A review of the home's policy #LTC-CA-WQ-205-02-01, titled "Infection Prevention: Cleaning, Disinfecting, and Sterilization", last revised in 2014, stated, "Hotel clean will be maintained in common use areas of the LTC homes, this means: d) bathroom fixtures including toilets, sinks, tubs, and showers are free of streaks, soil, stains, and soap scum. DOC #2 confirmed that the presence of unlabelled, used personal hygiene products was not consistent with the infection prevention and control practices in the home. DOC #2 also confirmed that specified shower areas were not cleaned and disinfected post usage, and confirmed that the home did not meet the legislative requirement. [s. 229. (4)]

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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #3: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

Observations of resident #033's room revealed they had a specified bed, and there were two assist rails attached to the bed, in the transfer position. The resident was not in bed at the time of the observation. The resident was observed ambulating independently around the unit, without use of gait aids. The resident could not be interviewed related to cognitive impairment.
A review of resident #033's current written plan of care directed to staff not to put the bed rails up while the resident was in bed. A review of the resident's most recent minimum data set (MDS) assessment, dated May 2017, indicated that two bed rails were used daily for the resident. A review of a document titled "Bed System Assessment", dated February 2017, indicated that no bed rails were required as the resident was able to safely enter and exit the bed, and bed rails were not used for the resident.
In an interview in June 2017, DOC #1 stated resident #033 had been assessed as not needing the bed rails when they were in bed; however, the MDS assessment which indicated that two bed rails were used for the resident daily, was incorrect. The DOC further stated the home was in the process of discussing the removal of bed rails from beds where they were not being used. [s. 6. (4) (a)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home received individualized personal care, including hygiene care and grooming, on a daily basis.

Resident #013 required extensive assistance with all activities of daily living (ADL) including personal hygiene, as per a review of the Minimum Data Set (MDS) Assessment dated April 2017. A review of the resident's current written plan of care, indicated that the resident preferred assistance with specified personal hygiene care on a daily basis with a specified device and required the assistance of personal support staff to complete this task as they were unable to complete this task independently. The resident was observed on three specified days in 2017, after the lunch services, and it was noted that they did not receive assistance with the specified hygiene care. In an interview, PSW #109 indicated that the resident required extensive assistance with ADL's and indicated that the specified care was not completed by staff. In an interview, registered staff #107 confirmed that the resident did not always receive the specified care, or the care was not provided properly because some personal care staff were unskilled with the task. In an interview, DOC #1 confirmed that the resident's personal care as per the resident's documented preference was not completed [s. 32.]

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Issued on this 18th day of July, 2017

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

Original report signed by the inspector.