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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Oct 13, 2020	2020_845585_0007	002679-20, 003515-20, 015963-20, 017377-20	Critical Incident System

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
7070 Derrycrest Drive MISSISSAUGA ON L5W 0G5

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

LEAH CURLE (585), PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 15, 16, 17, 18, 23, 24, 25, 28, 30 and October 1 and 2, 2020.

The following intakes were completed in this Critical Incident System (CIS) inspection:

Log #015963-20, CIS#2908-000013-20 was related to personal support services, Log #002679-20, CIS#2908-000002-20; Log #003515-20, CIS#2908-000003-20; and Log #017377-20, CIS#2908-000015-20 were related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with residents, personal support workers (PSWs), registered nursing staff, the social worker, Resident Assessment Instrument Minimum Data Set (RAI-MDS) Coordinator, Directors of Care and the Administrator.

During the course of the inspection, the inspectors observed residents, reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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. (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 failed to ensure that the care set out in resident #003, #004 and #008's plan of care in relation to a safety intervention was provided.

A) Resident #003 was injured due to a fall. Their care plan was updated and an intervention was added for their safety. On a date in September 2020, the intervention was not in place. Director of Care (DOC) #101 acknowledged the intervention should have been implemented. Without the safety intervention, the resident was at an increased risk of injury.

B) Resident #004's care plan included an intervention to be implemented for their safety. On a date in September 2020, the intervention was not in place. Without the safety intervention, the resident was at an increased risk of injury.

C) Resident #008 was at risk for falls. Their care plan included an intervention to be implemented for their safety. On a date in September 2020, the intervention was not in place. DOC #101 and DOC #107 acknowledged the intervention should have been implemented. Without the safety intervention, the resident was at an increased risk of injury.

Sources: Resident #003, #004 and #008's care plan, observations and interviews with resident #003, #004 and #008, interviews with Registered Practical Nurse #110, DOC #101 and DOC #107. [s. 6. (7)]

2. The licensee failed to ensure that the provision of care set out in residents' #004, #005 and #007's care plans in relation to monitoring was documented.

A) Resident #004's care plan stated they were to be monitored for safety related to falls. There was no documentation in the resident's records to support that the care had been provided. DOC #101 and DOC #107 confirmed the resident was to be monitored but there was a lack in documentation.

B) Resident #005's care plan stated they were to be monitored for safety related to falls. There was no documentation in the resident's records to support that the care had been provided. DOC #101 and a personal support worker (PSW) confirmed the resident was to be monitored but there was a lack in documentation.

C) Resident #007's care plan stated they were to be monitored for safety related to falls. DOC #101 and DOC #107 confirmed the resident was to be monitored but there was a lack in documentation.

Sources: Resident #004, #005 and 007's care plan, Point of Care records, interviews with a PSW, DOC #101 and DOC #107. [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 and ensure that the care set out in the plan of care is provided to the resident as specified in the plan; and that the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

Issued on this 21st day of October, 2020

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

Original report signed by the inspector.