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

Hamilton District
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Original Public Report

Report Issue Date: April 25, 2023	
Inspection Number: 2023-1392-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc.	
Long Term Care Home and City: Chartwell Waterford Long Term Care Residence, Oakville	
Lead Inspector Emmy Hartmann (748)	**Inspector Digital Signature** EmmyLou Hartmann Digitally signed by EmmyLou Hartmann Date: 2023.05.12 15:33:14 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 28-31, and April 3-6, 11-13, 18-19, 2023.

The following intakes were inspected:
- Intake #00004687, was related to improper/incompetent treatment of a resident resulting in injury.
- Intake #00006065, was related to an allegation of staff to resident physical abuse.
- Intake #00014277, was related to improper/incompetent care of a resident resulting in injury.
- Intake #00014872, was related to improper/incompetent treatment of a resident resulting in injury.
- Intake #00015487, was related to nutrition care and hydration.
- Intake #00016426, was related to an allegation of staff to resident physical abuse.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that there was a written plan of care for a resident, that set out clear directions related to the care of the resident's medical appliance.

The resident was observed to have a medical appliance.

A PSW identified that the directions pertaining to the care of the medical appliance was found in the care plan.

A nurse identified that there were specific instructions pertaining to the medical appliance that required the collaboration of different care staff. They also identified the frequency of when the medical appliance was to be replaced.

A review of the resident's care plan identified that these directions were not included.

The nurse added the information into the care plan.

Sources: Observation on a specified date; a resident's care plan; interviews with a Personal Support Worker (PSW) and Registered Nurse (RN).

[748]

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident related to personal care and bed mobility.

Rationale and Summary
The resident required two staff assistance for personal care, and bed mobility. On an identified date, the resident fell out of their bed while being provided care by one staff.

The home's investigation notes, and Director of Care (DOC) #102, confirmed that the PSW provided care to the resident alone, and the plan of care was not followed.

The resident sustained injuries, as a result of their plan of care not being followed.

Sources: A resident's care plan, and progress notes; the home's investigation notes; interview with DOC #102.

[748]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident.

Rationale and Summary
The resident required two staff assistance with the use of a sit to stand mechanical lift for toileting; and two staff assistance with the use of a ceiling or Hoyer lift for other transfers.

On an identified date, the resident had a change in condition, and was subsequently sent to hospital for further investigation. The resident sustained an injury.

The home's investigation notes, and DOC #102, identified that on the identified date, the resident was not transferred as per their assessed needs when staff used a sit to stand lift rather than a ceiling or Hoyer lift to transfer them out of bed. The investigation also identified that when the resident was toileted on the same day, the appropriate safety belt for the sit to stand lift was not applied around the resident's legs, and was not closed.

Although, the home was not able to determine that these events caused the resident's injury, the resident's safety was placed at risk.

Sources: A resident's care plan, and progress notes; the home's investigation notes; sit to stand lift manufacturer's instructions; interview with DOC #102.

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WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

The licensee has failed to ensure that there was a written plan of care for a resident that set out the planned care for the risk of infection.

The resident had a medical appliance. A nurse identified that residents with the medical appliance was at risk for infection, and they needed to be monitored for symptoms of infection, and assessed as needed. Another nurse identified that the resident had a history of infections, and was hospitalized previously as a result.

DOC #101 verified that there was no written plan of care for the resident's risk of infection.

Sources: A resident's care plan, progress notes; interviews with RNs, and DOC #101.

[748]