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 prévue le Loi de 2007 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

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

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jul 06, 2017;	2017_482640_0007 (A1)	005785-17	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 Wenleigh Long Term Care Residence
2065 Leanne Boulevard MISSISSAUGA ON L5K 2L6

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

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 prévue le Loi de 2007 les foyers de soins de longue durée

HEATHER PRESTON (640) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

As per request of the home, the compliance date was changed to August 25, 2017.

Issued on this 6 day of July 2017 (A1)

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

Original report signed by the inspector.

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 prévue le Loi de 2007 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

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

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 06, 2017;	2017_482640_0007 (A1)	005785-17	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 Wenleigh Long Term Care Residence
2065 Leanne Boulevard MISSISSAUGA ON L5K 2L6

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

HEATHER PRESTON (640) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 15, 16, 17, 20, 21, 22, 23, 24, 27, 28, 29, 30, 31, April 4, 5, 6 and 7, 2017. Araba Opong (465) was on site during the RQI process.

The following Critical Incidents, Complaint and Follow-up Inspections were inspected

concurrently with the Resident Quality Inspection (RQI).

Log #004470-17 Follow-up to order #1 LTCHA, 2007 S.O. 2007, c.8, s. 6. (11) Due Feb 28, 2017

The Critical Incidents included:

Log #030775-16 related to staff to resident abuse

Log #031674-16 related to staff to resident abuse

Log #031767-16 related to staff to resident abuse

Log #000586-17 related to improper care

Log #000629-17 related to alleged physical and verbal abuse

Log #001085-17 related to a resident fall

Log #005578-17 related to alleged verbal and emotional abuse

Log #006769-17 related to improper care/transferring

The complaints included;

Log #026956-16 related to resident care

Log #031231-16 related to alleged neglect

Log #006897-17 related to multiple issues related to care

Inquiries included;

Log #000222-17 related to missing medication

Log #005406-17 related to alleged abuse resident to resident

Log # 006591-17 related to emergency response to electrical sparking

During the course of the inspection, the inspector(s) spoke with Administrator, Resident Services Director of Care, Clinical Director of Care, Assistant Director of Care, Resident Assessment Instrument (RAI) Coordinator, Family Community Coordinator, Behaviour Support Ontario Registered Practical Nurse (BSO RPN) Coordinator, Registered Nurses, Registered Practical Nurse, Personal Support Workers, Environmental Supervisor, Housekeepers, Food Service Manager, Dietary Aides, Program and Support Service Manager, Residents, Families, Family Council President, Residents' Council President and Vice President, Chiropodist, Social Worker, Business Manager, Corporate Nurse Consultant, Physiotherapist and Registered Dietitian (RD).

During the course of the inspection, the inspector(s) toured the home, made observations, reviewed clinical records, reviewed policies, interviewed

residents, family members, staff, President of Resident Council and President of Family Council.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

18 WN(s)
11 VPC(s)
1 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. 6. (11)	CO #001	2016_467591_0011	527

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home protected residents from abuse by anyone and that residents were not neglected by the licensee or staff.

A) During Stage 1 of the RQI inspection, resident interview, resident #001 told the Long Term Care Home (LTCH) Inspector that they had been spoken to by Personal Support Worker (PSW) #126 during care and experienced discomfort. The home did submit a Critical Incident report to the Director and initiated an immediate investigation within the home. Review of the investigation notes concluded that PSW #126 had verbally and physically abused the resident. As a result, the home took action.

B) The home submitted a Critical Incident (CI) report to the Director regarding PSW #137 verbally abusing resident #001 The investigation notes were reviewed by the LTCH Inspector. The resident was interviewed during the inspection and restated the events and shared with the LTCH Inspector that they were very upset. Resident shared with the BSO RPN that the PSW did not provide care as required. Registered staff #107 was interviewed and confirmed that the resident was upset about the care they received from PSW #137. The investigation notes revealed that the PSW involved denied the accusations. During an interview with the Administrator, the Administrator confirmed that the investigation concluded that the resident was abused by the PSW and action was taken as a result. The home failed to ensure that the resident was protected from abuse.

C) The Critical Incident (CI) report indicated that resident #021 reported to the Director of Care (DOC) that PSW #138 was rough. The resident was crying when they were recounting the story to the DOC. During the provision of care, on more than one occasion, the PSW had been rough. The resident was aware of the need to be safe in their own home. The investigation notes indicated that this was not the first time the PSW was rough with the resident. The home interviewed a number of PSWs that provided direct care and all stated that they were always careful during provision of a specific care need and they needed to go slow as resident usually had pain. The resident was interviewed during the inspection and was able to recall the incident. They confirmed the actions of PSW #138 and was emotional about the incident. They stated that all other PSWs that provided care were always careful and this particular PSW was the only one that caused them pain. Investigation notes indicated that the PSW denied the incident. The Administrator was interviewed and confirmed that the home had completed an investigation, interviewed a number of PSWs and registered staff and concluded that the PSW was rough with the resident during care and took action. The home failed to ensure that resident was protected from abuse.

D) The Critical Incident (CI) Report was submitted to the Director of alleged

physical and verbal abuse of PSW #136 and PSW #134 towards resident #023. The CI report indicated that PSW #136 was rough with the resident during care. PSW #134 was present and spoke to the resident in an identified manner. Resident #023 was interviewed and was able to recall the incident and was emotional while recounting the story. PSW #134 did not witness the provision of care and denied the accusation. Registered staff #133 was interviewed. They indicated that PSW #136 reported to them an account of an incident that occurred between PSWs #136 and 134. The incident was immediately reported to the on call DOC by the registered staff. Investigation notes were reviewed and indicated the resident was able to recall details of the incident during the interview with the PSW Coordinator. PSW #136 denied the accusations. PSW #134 denied the accusations. The Administrator was interviewed and confirmed that the investigation concluded that the resident was emotionally abused by PSW #136 and action was taken. The home could not confirm the alleged accusations of PSW #134. The licensee failed to ensure that resident #023 was protected from abuse by anyone. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #018 was with staff when they requested care. The staff member and PSW #161 assisted the resident with the required care. The resident fell and sustained an injury.
The resident was assessed at risk for falls. The clinical record was reviewed and the written plan of care related to specific care directed staff not to leave the resident unattended. PSW #200 was interviewed and indicated that the resident rang the call bell and when they responded, they found the resident alone and unattended. The PSW confirmed the resident was not to be left unattended during provision of specified care. RN #107 was interviewed and also confirmed the resident was not to be left unattended during the provision of identified care need. The staff did not provide the care to the resident as specified in their written plan of care. [s. 6. (7)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when (c) care set out in the plan had not been effective.

Resident #005 was transferred to the hospital. The Assistant Director of Care notified the physician on call as a result. The resident returned to the home with a diagnosis. The written plan of care identified resident #005 to be at risk of the

diagnosis. Resident #005's family member notified the home of the resident's change in condition. RN #107 assessed the resident and found the resident to have unusual symptoms. Over several days, the resident continued to display symptoms. On three occasions during this time period, various nurses administered prescribed medication without effect. The Nurse Practitioner (NP) was called and was unavailable. No further attempts were made to contact a physician or the NP. Review of the 24 hour report book, the night nurse noted the resident's condition and requested the day nurse to contact the physician or NP. Interview with RN #117, the nurse on the day shift, who confirmed the physician and NP were not notified of the resident's persistent symptom. RN #117 told the Long Term Care Home (LTCH) Inspector that when a resident presents with an identified symptom and when a treatment for that symptom was not effective, it was expected the nurse notify the physician or delegate. During an interview with the Director of Care (DOC), the DOC told the LTCH Inspector it was the expectation of the home that the nurse was to call the physician on call if the NP was not available and that the physician or delegate be notified when a resident presents with an identified symptom. [s. 6. (10) (c)]

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 care set out in the plan of care is provided to the residents as specified in the plan and when the resident is reassessed, when the care set out in the plan is no longer effective, the plan of care is reviewed and revised, 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 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 in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with.

In accordance with r. 30 (1), Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under Ontario Regulation 48(1)4 requires the home to have a pain management program to identify pain in residents and manage pain.

Resident #009 sustained an injury in 2017. According to the home's investigative and interview notes and interviews with RPN #154 and the Administrator, during provision of care, the resident sustained an injury. The resident was in pain as documented in the staff statements, in the progress notes and based on the interviews with the RPN and Administrator.
The home's policy called "Pain", number LTC-CA-WQ-200-05-04, and last revised in July 2016, directed "Ongoing Registered Staff and all other members of the interdisciplinary care team are to be alert to signs that a resident may be experiencing pain. Team members observing any of these signs are to report these to Registered Staff immediately". PSW #153 continued with the provision of care following the incident before notifying RPN #154 that the resident was in pain.
RPN #154 documented in the progress notes that the resident was guarding an identified area and demonstrating signs of pain RPN #154 confirmed this in an interview.
PSW #153 failed to notify RPN #154 immediately when the resident was in pain and did not comply with the home's pain policy and procedures. [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 the home complies with their policies and procedures, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

A) During Stage 1 of Resident Quality Inspection, resident interview and observation, resident #001 was observed in bed with both right and left bed rails in the up position. The policy Bed System Assessment, policy number LTC-CA-ON-200-07-22 directed staff to complete an assessment for bed system safety when any part of the bed system was changed or bed rails were implemented. During clinical record review, a Bed System Assessment was completed related to the use of one bed rail. There were no further assessments completed with the implementation of two bed rails for bed mobility or the implementation of a high/low bed. During an interview, RN #117, confirmed there was no subsequent assessment of the bed system for resident #001 when the bed was changed and two bed rails were implemented and it was the expectation of the home that a bed system assessment be completed. During an interview, the Clinical Director of Care confirmed the expectation of the home was that a bed system assessment was to be done when the bed was changed and the two bed rails were implemented.

B) Resident #011 was observed in bed and had two bed rails applied while in bed. The written plan of care at the time of observation indicated that the resident required two bed rails to be applied while in bed. The clinical record review revealed that the most recent bed system assessment was completed on admission and stated that resident required only one bed rail to be applied while in bed. In an interview, PSW #115 stated that resident was moved to a different room after they returned from the hospital and required to have two bed rails in bed. The registered staff #107 confirmed that the resident required two bed rails to be up while in bed. The Clinical Director of Care confirmed that the resident was not re-assessed when two bed rails were applied for the resident when their condition had changed. The home's policy titled "Bed System Assessment", policy number LTC-CA-ON-200-07-22 directed staff to reassess the resident when there were changes to the bed system.
The home failed to ensure that the resident was assessed for two bed rails when their condition changed. [s. 15. (1) (a)]

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 where bed rails are used, the resident is to be assessed and the bed system to be evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written policy that promoted zero tolerance of abuse and neglect of residents and that it was complied with.

A) Resident #001 reported an allegation of abuse to the home. The home's policy, Abuse Allegations and Follow-Up, policy # LTC-CA-WQ-100-05-02 directed the investigator of the alleged abuse to follow the Investigation Process in conjunction with Investigation Policy and Template, complete a Resident Incident Report form and complete a Chartwell Incident Report and investigation policy checklist/process and was responsible to ensure that all documentation was completed in the manner prescribed by the regulatory body.
Review of the investigation record for resident #001, revealed no investigation template, Resident Incident Report and Chartwell Incident Report checklist. During

an interview with the Administrator, the Administrator informed the LTCH Inspector that these documents were not used during this investigation as they were a repeat of the Critical Incident(CI) report information. The Administrator told the LTCH Inspector that the CI report was used as the investigation template or checklist and confirmed the documents listed in the home's Abuse Allegations and Follow-Up policy were not implemented.
The home had submitted a Critical Incident Report to the Director related to an allegation of abuse towards resident #001. The review of resident's health care records revealed that the Resident Incident Report was not completed after the incident. The Administrator confirmed in an interview that they did not complete one for this incident.

B) The home had submitted a Critical Incident Report to the Director related to an allegation of physical abuse towards resident #020. The allegation could not be confirmed; however the review of resident's health care records revealed that the Resident Incident Report was not completed. The Administrator confirmed in an interview that they did not complete one for this incident.

C) The home had submitted a Critical Incident Report to the Director related to an allegation of abuse towards resident #021. The review of resident's health care records revealed that the Resident Incident Report was not completed after the incident. The Administrator confirmed in an interview that they did not complete one for this incident

D) The home had submitted a Critical Incident Report to the Director related to an allegation of abuse towards resident #023. The review of resident's health care records revealed that the Resident Incident Report was not completed after the incident. The Administrator confirmed in an interview that they did not complete one for this incident. [s. 20. (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 there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #010 returned from the hospital with an area of altered skin integrity, which deteriorated after return to the home. Resident #010 had a history of altered skin integrity and was on a turning and repositioning program as one of the interventions to prevent skin breakdown. The resident was to be repositioned by staff every one to two hours when in bed.
PSW #129 was observed implementing the resident's interventions to prevent skin breakdown, as outlined in the written plan of care. The clinical record was reviewed and the turning and repositioning was inconsistently documented by the PSWs.
PSWs #129 and #132 confirmed that they document the resident's turning and repositioning every two hours in Point Click Care (POC). RN #127 was interviewed and confirmed that the PSWs were expected to document turning and repositioning of resident #010 every two hours.
The staff failed to ensure that interventions to prevent skin breakdown were documented with respect to resident #010 under the skin and wound program. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home received preventative and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

An anonymous complaint was submitted to the LTCH Inspectors identifying a concern that the home charged for nail care and when residents come to live in the home they were asked by the home "who will cut resident's nails? You? Or we can get an outside person for $25.00". The complainant believed that nail care should be provided by the home at no cost.
During the inspection, LTCH Inspector interviewed PSW staff and registered staff. PSW #148 and #129 stated that the PSWs did not cut residents' toe nails and only finger nail care was provided to residents by them on bath days. The PSWs indicated that toe nail care was provided by the Chiropodist. Registered staff #133 confirmed that the Chiropodist provided basic and professional toe nail care to most residents in the home. The Chiropodist regularly came to the home every six weeks and provide toe nail care to residents that pay for the service.
An interviewed with resident #043 who stated that they were not aware that the home could provide the basic toe nail care at no charge; this information was not shared during admission. Interview with family member of resident #046 who stated that they were not aware of the fact that the home provided basic foot care services at no charge. The family member could not recall whether the home shared any information about foot care services provided during the admission process.

LTCH Inspector interviewed the Chiropodist. The Chiropodist indicated that they come to the home as per schedule about every six weeks. Service was being provided to residents that consented and paid for the service upon admission. Those that have not consented could bring someone else to do their toe nail care or could take residents to have the foot care done outside. There were also residents that prefer to have families cut their toe nails. The Chiropodist stated that they saw the majority of the residents in the home and charged $25.00 per visit. They also confirmed that they provided basic foot care to residents in the home and charged the same amount.

The LTCH Inspector interviewed the Social Worker who did the admissions of residents to the home. They indicated that upon admission, they inform families and residents about services that were included in the accommodation fee and which services were available on a fee for service basis. One of the services that were not included in the monthly accommodation fee was the basic foot care or chiropody service. Families were being given an option to purchase the chiropody service which was $25.00 per visit; they could either opt in or opt out. The Social Worker confirmed that they had not informed families and residents that basic foot care could be provided by the home at no cost.

In an interview with the Business Manager who also did admissions of residents to the home, stated that they never informed the families and residents that the home provided basic foot care at no cost. On admission residents and families were informed about the extra charges that were not included in the accommodation fee and foot care was one of them. They indicated during the interview, that families and residents were informed that the home had a chiropodist who came in every six weeks to provide foot care to residents and the service was $25.00 per visit. If families decided not to get the service they could either cut their loved ones toe nails or could take them to an outside service.

The LTC Care Staff Guide Book stated "residents who have toe nail care performed by a Chiropodist or Foot Care Nurse will be identified to Care Staff by Registered staff. Residents will have toe nails (if not seen by a Chiropodist or Foot Care Nurse) inspected on the first bath/shower day of the week." The guide further explained the procedure for nail care including fingers and toes.

The admission package was reviewed and listed the services that were not included in the accommodation fee but could be purchased at a cost. Chiropody was one of them and stated that this service was not covered by OHIP and was a service available for the provision of professional foot care.

The Administrator confirmed that 136 out of 161 residents, 84 percent (%), paid for the Chiropody service in the home.

The LTCH Inspector interviewed the DOC and indicated that the PSWs in the

home did not provide basic foot care to residents and only residents who wished to pay for a professional service got their toe nails done by the Chiropodist. The DOC was not aware that staff were not providing toe nail care and confirmed that the home's policy was that the PSW were to provide finger and basic toe nail care at no charge.
The home failed to ensure that residents were provided preventive and basic nail care services by the home. [s. 35. (1)]

2. The licensee has failed to ensure that the resident received fingernail care including the cutting of fingernails.

Observation of resident #006 during Stage 1 of the RQI inspection revealed their finger nails to be long and uneven with dark coloured debris under seven finger nails. During an interview with Personal Support Worker (PSW) #119, PSW told the LTCH Inspector that resident's nails were to be cleaned and trimmed during bathing time and as needed. RPN #118 observed the resident and confirmed their nails to be unclean and untrimmed and told the LTCH Inspector that staff were expected to complete the nail care during the bath and as needed. The Clinical Director of Care confirmed the resident's nail care was not done as expected during bathing or as needed. [s. 35. (2)]

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 residents of the home receive preventative and basic foot care services including the cutting of toenails, to ensure comfort and to prevent infection and to ensure that the residents receive fingernail care to include the cutting of fingernails, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Resident #021 had a plan of care indicating that they required two person extensive assistance with transfers. The home submitted a CI report related to alleged staff to resident abuse whereby resident #021 sustained an injury. The investigation notes revealed that PSW #137 transferred the resident alone and as a result the resident sustained the injury. The interview with PSW #134 who discovered the injury, indicated that the resident required two person assistance for transfers and they did not assist PSW #137 with the transfer. The Administrator confirmed that in an interview with the PSW #137 during the investigation, confirmed who that they did transfer the resident on their own. Through the investigation the home concluded that the PSW used an unsafe transfer and as a result the resident sustained an injury.
The home failed to ensure that staff used safe transferring techniques when assisting residents. [s. 36.]

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 that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, (a) procedures were developed and implemented to ensure that, (iv) there was a process to report and locate residents' lost clothing and personal items.

During Stage 1 of the Resident Quality Inspection (RQI) resident #001, #008 and #016 identified, during the resident interview, that they had missing clothing, they had notified the staff and they heard nothing from the staff whether they found their missing clothing or not.
Residents' Council identified concerns that laundry was going to the wrong person and going missing. The Environmental Services Supervisor's (ES) response was to meet with the staff and create a memo to review procedures to ensure labels were on residents' clothes and that the residents' clothes were filed away accurately in the correct residents' closet.
The home's policy "Personal Clothing – Missing", number ALL-CA-ALL-500-10-02, directed staff to check the lost and found clothing area for an initial search for the missing items; the person receiving the report of lost clothing was to document all information on the missing clothing report form; an immediate search of the home area was to be completed by the nursing department; and if the clothing was not found then the Environmental Supervisor(ES) was to be contacted and initiate a search in the laundry services area. The missing clothing form was to be posted in the laundry area and the ES was to contact the person reporting the missing item (s) and report the results of the search.
The ES was interviewed and was not aware of the missing clothing for the three residents and had no "Missing Clothing Report Form" submitted by registered staff to the ES. The ES confirmed that the staff did not implement the home's procedures for residents' lost clothing. [s. 89. (1) (a) (iii)]

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 procedures are developed and implemented to ensure that there is a process to report and locate resident's lost clothing and personal items, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that electrical equipment was kept in good repair, and maintained and cleaned at a level that met manufacturer specification.

Interview with the Clinical Director of Care (CDOC), revealed the home used the DeVilbiss Vacu-Aide Compact suction units, 7310 series, the units were portable and there was one available to share between two adjoining dining rooms and each nurses station had a back up portable suction machine. The CDOC stated no one checks the suction machines to ensure they were operational. The CDOC checked monthly, to ensure the supplies were available with the suction machine but did not check the suction machine or change the bacterial filter. Manufacturer's instruction directed the home to change the bacterial filter every one to two months or if overflow occurred. The manufacturer's instruction directed the home to wipe the outside housing with a clean cloth dampened with commercial disinfectant/detergent. This practice did not occur in the home.
Review of the home areas by the CDOC and Inspector #640 revealed the following; The portable suction unit in one dining room was non-functional, meaning when turned on, the lights flash and the unit groans without providing suction. The bacterial filter, filter paper inside, had deteriorated and was in small pieces, one piece of which was at one of the openings of the filter/tubing connection. The back up suction unit at the nurses station, was operational with the suction set at 300 millimetres of mercury (mm Hg). The back up system at another nurse's station, required a new bacterial filter as the filter paper was beginning to deteriorate in one corner. The back up suction unit at the nurse's station did work but supplied suction at 600 mm Hg without any resistance applied. A third dining room suction unit did work and was set at 50 mm Hg. The back up unit was not at the nurse's station. RN #100 was not aware there was a suction unit available at the nurse's station. On a fourth home area, there was no back up suction unit available.
Interview with the Director of Care and the Corporate Nurse Consultant who confirmed the home did not have a procedure developed or implemented to ensure that electrical equipment, specifically the suction units, were kept in good repair, and maintained and cleaned at a level that met manufacturer's specifications at a minimum. [s. 90. (2) (a)]

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 procedures are developed and implemented to ensure that electrical equipment is kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4): 1. An emergency, including fire, unplanned evacuation or intake of evacuees.

On a specific date in 2017, PSW #143 and #144 identified that there was a fire and sparking in an electrical outlet in an identified area. RN #145 called 911 and notified the on-call Manager. The staff did not report the critical incident to the Director immediately as required in the legislation.
The Administrator was interviewed and indicated he and the ES responded to the staff and provided guidance and support to isolate the area at the electrical panel at the time of the incident. The Administrator identified that the Fire Department attended the home and the Fire Chief left a "Notice to the Building Owner" including the actions that were to be taken to maintain all life safety systems and have all repairs completed. The ES and Administrator acted on the notice by the Fire Chief and the electrical work was completed by a licensed electrician and the Administrator faxed a copy of the report to the Fire Chief. The residents were not harmed during the incident and did not require evacuation.
The home failed to immediately notify the Director of the emergency. [s. 107. (1) 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 the Director is immediately informed, in as much detail as possible in an emergency, including fire, unplanned evacuation or intake of evacuees, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the physical device was applied in accordance with the manufacturer's instructions.

Resident was observed and while in wheelchair, had a device applied that was loose. The PSW #102 was interviewed and confirmed that the device was loose and indicated that it should have been applied in a way that you could only place two fingers through. Registered staff #101 confirmed the same and indicated that there were no manufacturer's instructions available on the unit for the application of the device. The interview with the DOC #121 indicated that each unit kept the general instructions from the manufacturer; however, those did not provide direction to staff on how to correctly apply the particular device used by resident #030. The DOC #121 stated that when a new device was introduced on a home area the staff would be provided with an in-service on how to apply that device. The home did not keep records of the education material related to the application of the device and did not keep records of the number of staff that received the in-service.
DOC #121 provided a copy of manufacturer's instructions that were requested by the home from the manufacturer directed the staff to " tension the Harness by grasping the buckle and pulling the webbing through the buckle (using the 'D' ring) until the harness was not too loose to be ineffective nor too tight to cause discomfort". The DOC stated instructions will be kept in resident's chart from now on.
The home failed to ensure that the device was applied in accordance with manufacturer's instructions. [s. 110. (1) 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 a physical device is applied in accordance with the manufacturer's instructions, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007, 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:
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).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident had the right to 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.

A) The LTCH Inspector observed a sheet of paper that had resident #031's name on it with a summary of that resident's behaviours and interventions in place to address these behaviours, sitting on the ledge at the nursing station visible and accessible to anyone walking by. The registered staff were not present at the time of the observation. When registered staff #133 returned to the nursing station they had indicated that this piece of paper should have been placed inside the binder that is kept at the nursing station called shift report binder. Registered staff confirmed that personal health information about residents should be kept confidential and not visible or accessible to visitors.
B) The LTCH Inspector observed a binder that had resident #031, 044, 045, 042 and 043's name on six separate sheets of paper, which were more than half way out of the top of the binder, with a summary of resident's behaviours and/or continence observations sitting on the top ledge at the nursing station, visible and accessible to anyone walking by. No staff was present at the time of the observation. When registered staff #133 returned to the nursing station they had indicated that the visible contents of the binder, should have been placed inside the unit report binder and kept on the lower desk at the nursing station outside of reach and view of the public. Registered staff confirmed that personal health information about residents and the binder were visible and accessible to the public and they should be kept confidential and not visible or accessible to the public. [s. 3. (1) 11. iv.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Observation of resident #006 revealed their finger nails to be long, uneven and with dark coloured debris under seven finger nails. The resident's written plan of care directed staff to bath the resident as per the bath schedule. The bath schedule identified one day per week. Documentation in Point of Care revealed the resident was bathed as per the bath schedule. During an interview with Personal Support Worker (PSW) #119, PSW told the LTCH Inspector that residents were bathed twice weekly. RPN #118 confirmed the resident was getting one shower per week based on the bath list and the POC documentation and confirmed the resident should be getting two showers per week and the resident had not notified the home of preferring only one bath day per week. Documentation of bathing for resident #006 was reviewed with the Clinical Director of Care who confirmed the resident was being bathed once a week and the resident should be scheduled for a minimum of two bath days per week. [s. 33. (1)]

2. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

During Stage 1 resident interview, resident #001 informed the LTCH Inspector that bathing was done twice weekly and that they received a shower both times. The resident told the LTCH Inspector their preference was for a bath. During clinical record review, the Admission note found in Point Click Care (PCC) did not include bathing preference. The Admission Assessment in PCC did not include bathing preference. The admission written plan of care did not include bathing preference. The Kardex did not include bathing preference and the bath list did not include bathing preference for resident #001. An Interdisciplinary Care Conference included comment section from resident/SDM which stated the resident preferred to have a bath. Interview with PSW #125 included that the resident was showered twice a week. During an interview, RN #117 confirmed there was no documentation related resident #001's bathing preference and the resident was not receiving the bathing preference of a bath. [s. 33. (1)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes 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 require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that it was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Resident #016 had a plan of care indicating that they were incontinent of bowel. The clinical record review indicated that at the time of the quarterly reviews, the resident showed a change in bowel incontinence and there was no assessment completed at those times. The registered staff #113 and the RAI Coordinator stated that it was an expectation that a continence assessment was completed when there was a change in continence. The RAI Coordinator confirmed that the registered staff did not assess the resident when they had a change in bowel incontinence. [s. 51. (2) (a)]

WN #16: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that when the Residents' Council advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee was required, within 10 days of receiving the advice, to respond to the Resident's Council.

The Residents' Council advised the home of concerns and/or suggestions based on their meeting minutes from October, November and December, 2016, as well as January, 2017. The concerns and/or suggestions were not responded to consistently in writing within ten days of the home being advised.
The Residents' Council indicated that they would get some responses on the "Resident Council Recommendation/Concerns Response Form". In addition, upon review of the Residents' Council minutes there were the same concerns identified by residents at the subsequent meetings. Those concerns included: long wait times for response by staff to call bells; unsafe dining room chairs; laundry issues, such as missing personal clothing, resident clothing being filed in the wrong residents' room, and resident personal clothing being discoloured as their clothes were not sorted and the implementation of a suggestion box.
The Residents' Council, the Assistant and the Administrator confirmed that the home did not respond in writing within ten days of receiving the Residents' Council advice related to concerns or recommendations on a consistent basis. [s. 57. (2)]

WN #17: The Licensee has failed to comply with LTCHA, 2007, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when Family Council advised the licensee of concerns or recommendations, the licensee was required, within 10 days of receiving the advice, to respond to Family Council in writing.

During interview of Family Council President, the President informed the LTCH Inspector that the Administrator of the home was given a copy of the minutes of the Family Council meetings, by the assistant to the Council, for signature. The Family Council minutes from February, 2017 included concerns and recommendations of Family Council regarding (a) the home's communication with family when an outbreak was declared, (b) some family members were "told" by staff to leave the home during the outbreak and (c) a request for "WiFi" in the home. The minutes were signed by the Administrator, but not dated. In February, 2017, the President of Family Council sent an email to the Administrator regarding concern about bed linens being worn thin and had splits in them. The next email from the President to the Administrator was in March, 2017, requesting a response to the message sent in February 2017. The Administrator responded in March, 2017, stating what actions were put in place to address the concern regarding the linens. During an interview with the Administrator, the Administrator confirmed there was no response, verbal or written, to the concerns listed in the February, 2017, Family Council meeting minutes and there was no written response within 10 days regarding the concern in second February, 2017, email. [s. 60. (2)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or a medication cart, that was used exclusively for drugs.

A) The LTCH Inspector found a medication that belonged to resident #027, in their room sitting on the night stand. The clinical records were reviewed and the resident did not have an order to self administer or keep drugs in their room. Registered staff #100 confirmed that it should not have been left in resident's room.

B) While observing resident #028's room, LTCH Inspector found a medication on the night stand. The clinical records were reviewed and the resident did not have an order to self administer or keep drugs in their room. Registered staff #100 confirmed that the medication was administered by registered staff and should not have been left in resident's room.
The licensee failed to ensure that drugs were stored in the medication cart as confirmed by registered staff. [s. 129. (1)]

Issued on this 6 day of July 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de 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

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : HEATHER PRESTON (640) - (A1)

Inspection No. / No de l'inspection : 2017_482640_0007 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 005785-17 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Jul 06, 2017;(A1)

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

LTC Home / Foyer de SLD :
Chartwell Wenleigh Long Term Care Residence
2065 Leanne Boulevard, MISSISSAUGA, ON, L5K-2L6

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Peter Puiatti

---

To Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

1) The licensee shall provide all staff retraining on the home's prevention of abuse policy and legislation that promotes zero tolerance of abuse and neglect of all residents by anyone, specifically verbal abuse and rough handling.
2) The licensee shall implement an auditing process and analyze all abusive incidents to be included in the home's annual evaluation of the prevention of abuse program.

Grounds / Motifs :

1. The non-compliance was issued as a compliance order (CO) due to a severity level of "actual harm/risk", a scope of "pattern" and
a compliance history in the last three years of "ongoing non-compliance of a voluntary plan of correction (VPC)."

The Critical Incident (CI) Report was submitted to the Director of alleged physical and verbal abuse of PSW #136 and PSW #134 towards resident #023. The CI report indicated that PSW #136 was rough with the resident during care. PSW #134 was present and spoke to the resident in an identified manner. Resident #023 was interviewed and was able to recall the incident and was emotional while recounting the story. PSW #134 did not witness the provision of care and denied the accusation. Registered staff #133 was interviewed. They indicated that PSW #136 reported to them an account of an incident that occurred between PSWs #136 and 134. The incident was immediately reported to the on call DOC by the registered staff. Investigation notes were reviewed and indicated the resident was able to recall details of the incident during the interview with the PSW Coordinator. PSW #136 denied the accusations. PSW #134 denied the accusations. The Administrator was interviewed and confirmed that the investigation concluded that the resident was emotionally abused by PSW #136 and action was taken. The home could not confirm the alleged accusations of PSW #134. The licensee failed to ensure that resident #023 was protected from abuse by anyone. [s. 19. (1)] (561)

2. The Critical Incident (CI) report indicated that resident #021 reported to the Director of Care (DOC) that PSW #138 was rough. The resident was crying when they were recounting the story to the DOC. During the provision of care, on more than one occasion, the PSW had been rough. The resident was aware of the need to be safe in their own home. The investigation notes indicated that this was not the first time the PSW was rough with the resident. The home interviewed a number of PSWs that provided direct care and all stated that they were always careful during provision of a specific care need and they needed to go slow as resident usually had pain. The resident was interviewed during the inspection and was able to recall the incident. They confirmed the actions of PSW #138 and was emotional about the incident. They stated that all other PSWs that provided care were always careful and this particular PSW was the only one that caused them pain. Investigation notes indicated that the PSW denied the incident. The Administrator was interviewed and confirmed that the home had completed an investigation, interviewed a number of PSWs and registered staff and concluded that the PSW was rough with the resident during care and took action. The home failed to ensure that resident was protected from abuse.

(561)

3. The home submitted a Critical Incident (CI) report to the Director regarding PSW #137 verbally abusing resident #001 The investigation notes were reviewed by the LTCH Inspector. The resident was interviewed during the inspection and restated the events and shared with the LTCH Inspector that they were very upset. Resident shared with the BSO RPN that the PSW did not provide care as required. Registered staff #107 was interviewed and confirmed that the resident was upset about the care they received from PSW #137. The investigation notes revealed that the PSW involved denied the accusations. During an interview with the Administrator, the Administrator confirmed that the investigation concluded that the resident was abused by the PSW and action was taken as a result. The home failed to ensure that the resident was protected from abuse. (561)

4. During Stage 1 of the RQI inspection, resident interview, resident #001 told the Long Term Care Home (LTCH) Inspector that they had been spoken to by Personal Support Worker (PSW) #126 during care and experienced discomfort. The home did submit a Critical Incident report to the Director and initiated an immediate investigation within the home. Review of the investigation notes concluded that PSW #126 had verbally and physically abused the resident. As a result, the home took action.
(640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Aug 25, 2017(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector
Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 6 day of July 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : HEATHER PRESTON - (A1)

Service Area Office /
Bureau régional de services : Hamilton