Ontario

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

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: July 9, 2024

Inspection Number: 2024-1365-0002

Inspection Type:
Complaint
Critical Incident

Licensee: Regency LTC Operating Limited Partnership, by it general partners, Regency Operator GP Inc. and AgeCare Iris Management Ltd.

Long Term Care Home and City: AgeCare West Williams, Kitchener

Lead Inspector	**Inspector Digital Signature**
Diane Schilling (000736)	Diane Schilling Digitally signed by Diane Schilling Date: 2024.07.18 11:43:55 -04'00'

Additional Inspector(s)
Yami Salam (000688)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 12-14, 18-21, 24-26 & 2024

The following intake(s) were inspected:
- Intake: #00113711 – compliant related to wound care
- Intake: #00114024 – complaint related to resident care
- Intake: #00114846 – related to alleged abuse
- Intake: #00116981 - related to alleged abuse

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

Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

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)
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

The licensee failed to implement their procedure for

(a) cleaning of the home, including,
(i) privacy curtains

Rationale and Summary
An inspector observed the curtains in a room to be visibly dirty.

Several days later, the inspector observed the curtains to be cleaned.

The home's Environment Services Manager stated that curtains should be cleaned monthly and as required.

Sources: Observations, interviews with staff
Resolved June 18, 2024
[000736]

Date Remedy Implemented: June 18, 2024

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure that the written plan of care gave clear direction to staff and others who are providing care to the resident regarding a mobility accessory.

Rationale and summary
The care plan for a resident did not say when the mobility accessory should be used.

The Director of Care (DOC) said that the care plan should include clear direction regarding use of the mobility accessory.

A personal support worker (PSW) stated that it was confusing as to when to use the mobility accessory for that resident.

When there are unclear care directions for the use of the mobility accessory, there was a risk that staff may not provide care as required for the resident.

Sources: A resident clinical record, interview with DOC and others.
[000736]

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

The licensee failed to protect a resident from physical abuse.
As per O. Reg. 246/22 s. 2 (1), "physical abuse" means, the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary:
A resident sustained an injury during an altercation with another resident.

The resident had a history of expressive behaviours with other residents on several occasions since their admission to the home.

Failure to protect a resident from physical abuse by another resident resulted in their injury.

Sources: Clinical record review of the residents, home's internal investigations, and interview with DOC and others.
[000688]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure a person who has reasonable grounds to suspect improper care of a resident that resulted in harm or a risk of harm to the resident immediately report the suspicion and the information upon which it is based to the Director.

Rationale and summary
The home received a complainant alleging the improper care of a resident. Multiple

staff members, including the DOC said that the allegations made should have been reported to the Director.

The Director was not informed until almost two months after the complaint was received.

When the home did not immediately report the allegations of improper care, the Director was not able to take necessary actions if it had been required.

Sources: resident clinical record, interviews with DOC and others
[000736]

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The Licensee failed to ensure a resident received immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection as required.

Rational and summary:
A resident had a wound that required treatment, however, the treatment was not

implemented as ordered. The resident's wound was later assessed by a would care specialist and was identified to have deteriorated since their initial assessment.

The resident was at risk of delayed wound healing due to staff not following the ordered treatment.

Sources: Review of resident clinical record, interview with the DOC and others. [000688]

WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (c)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure injuries, skin tears or wounds and promote healing;

The licensee has failed to ensure that supplies were readily available at the home as required to treat wounds and promote healing.

Rational and summary:
A resident had an order that required a specific product for treatment. A staff member was observed applying a different product than what was ordered.

A Registered Nurse (RN) said that the requested product was on backorder, necessitating the use of alternative products. They stated that there were times when substitutes must be used for the resident due to supplies not being available.

The resident noted that the home frequently runs out of supplies.

A review of the specialized requisition for a two-month period revealed insufficient supplies were ordered.

The DOC stated that staff are expected to maintain sufficient supplies of specialized products through weekly orders.

The resident was at risk of delayed wound healing when the home failed to maintain sufficient supply of the specialized products.

Source: Resident's clinical records, review of order requisition, interview with DOC and others.
[000688]

WRITTEN NOTIFICATION: Dealing with complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was investigated and resolved where possible, and a response that complied with paragraph 3 was provided within ten business days of the receipt of the complaint.

Rationale and Summary

Multiple complaints alleging improper care of a resident were made to the home. A response regarding the issues identified in the complaints was not provided to the complainant.

By not responding to the complainant, it may have resulted in insufficient communication and investigation of the concerns.

Sources: Critical incident report, complaints regarding improper care, interviews with DOC and others.
[000736]