Ontario

**Ministry of Health and Long-Term Care**

**Inspection Report under the Long-Term Care Homes Act, 2007**

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée**


**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

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| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Feb 22, 2017 | 2016_215123_0014 | 031363-16 | 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 Willowgrove Long Term Care Residence
1217 Old Mohawk Road ANCASTER ON L9K 1P6

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

MELODY GRAY (123), CAROL POLCZ (156)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): November 1, 2, 3, 8, 9, 10, 15, 16, 17, 18, 21, 22, 23, 24, 25, and 28, 2016**

**The following inspections were completed concurrently with the RQI:**
**Complaints:**
**032924-16 related to responsive behaviours**
**032939-16 related to responsive behaviours**

**Critical Incidents**
**004026-16 related to responsive behaviours**
**017890-16 related to alleged abuse**
**019621-16 related to alleged abuse**
**021274-16 related to alleged abuse**
**027191-16 related to alleged abuse**
**029456-16 related to alleged neglect**
**029810-16 related to alleged abuse**
**032047-16 related to improper feeding techniques**
**032736-16 related to alleged abuse**
**033314-16 related to alleged resident to resident abuse**

**During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSWs), dietary staff, registered staff, Continence Product Lead, Volunteer Coordinator, Directors of Care (DsOC), Resident Assessment Instrument (RAI) Coordinator and the Administrator.**
**The Inspectors also toured the home; reviewed the home's records including policies and procedures; reviewed residents' records; reviewed the medication management system and observed infection prevention and control practices.**

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

**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Family Council**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**
**Responsive Behaviours**
**Skin and Wound Care**

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

- **10 WN(s)**
- **6 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 91. Resident charges**

**Specifically failed to comply with the following:**

**s. 91. (4) A licensee shall not accept payment from or on behalf of a resident for anything that the licensee is prohibited from charging for under subsection (1) and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee's behalf. 2007, c. 8, s. 91. (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that they did not cause or permit anyone to make a

charge or accept such a payment on the licensee’s behalf.
Ontario Regulation 79/10 section 245 paragraph 1 identified the following:
"The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the
Act: 1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from, i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and ii. the Minister under section 90 of the Act".
The licensee received funding from the local health integration network under section 19 of the Local Health System Integration Act, 2006, for goods and services funded by the local health integration network under their service accountability agreement for continence care supplies. The Long Term Care Home (LTCH) Policy, LTCH Required Goods, Equipment, Supplies and Services, dated July 1, 2010, identified that:
"The licensee must provide the following goods, equipment, supplies and services to long-term care (LTC) home residents at no charge, other than the accommodation charge payable under the Long-Term Care Homes Act, 2007 (LTCHA), using the funding the licensee receives from the Local Health Integration Network under the Local Health System Integration Act, 2006 (LHSIA) or the Minister under the LTCHA or accommodation charges received under the LTCHA.
2.1 Required Goods, Equipment, Supplies and Equipment
2.1.2 Continence Management Supplies
Continence management supplies including, but not limited to:
a. A range of continence care products in accordance with section 51 of the Regulation under the LTCHA".
A pull up style incontinent product must be provided as part of the range of continence care products to be provided at no charge by the home. The licensee permitted the resident's representative to make a charge or accept a payment on the licensee’s behalf for continence care products, which they received funding from the local health integration network under their service accountability agreement.

A) Resident #006 was admitted to the home on an identified date in January, 2016. The plan of care for the resident indicated that they wore a pull-up style incontinent product and the home was to notify family when the resident needed more incontinent products. The resident required one staff to provide extensive assistance with toileting but that the resident was able to participate. Interview with the Personal Support Worker (PSW) Coordinator and Continence Product Lead confirmed that the resident was suitable for the pull-up style incontinent product. PSW #116 and #107 confirmed that the resident

currently wore a pull-up style incontinent product. The Director of Care (DOC) confirmed that the home was now supplying the incontinent product for the resident.

B) Resident #042 was admitted to the home on an identified date in May, 2014. The plan of care for the resident indicated that the resident wore a pull-up style incontinent product that the family was to provide. The plan indicated that one staff member was to provide supervision with toileting; limited assistance if fatigued and the resident would direct staff to provide assistance. PSWs #116 and #107 confirmed that the resident currently wore a pull-up style product. Interview with the resident confirmed that their family provided the pull-up style incontinent product; that they had never been given an option of trying a pull-up style product provided by the home and they would like to try them. The DOC confirmed that the resident will be given the option to try a pull up style incontinent product provided by the home.

C) Resident #046 was admitted to the home on an identified date in February, 2015. PSW #117 reported that the resident had worn a pull-up style incontinent product provided by family. Pull-up style incontinent products were found in the resident's room. However, staff reported that the resident recently had changed to using a brief and no longer used the pull-up style product. The plan of care indicated that the resident was frequently incontinent but was able to recognize the urge to void most of the time. The plan indicated that the resident required assistance with toileting. One to two staff were to provide limited to extensive assistance for toileting. At times, the resident was able to be toileted by one staff, other times if resistive, two staff were needed. The DOC confirmed that the resident no longer used the pull-up style incontinent product.

D) Resident #043 was admitted to the home on an identified date in November, 2012. The DOC confirmed that the resident had been wearing pull-up style incontinent product provided by the family but was now using a brief style incontinence product. The plan of care for the resident indicated that the resident was frequently incontinent and required assistance with toileting. Interview with PSW #119 confirmed that the resident used to wear a pull-up style product as of two to three weeks ago but was now using a brief.

E) Resident #044 was admitted to the home on an identified date in June, 2014. The plan of care for the resident indicated that the resident required assistance with toileting and wore a pull-up style product which was supplied by their family. PSW #118 confirmed that the resident used pull-up style incontinent product supplied by the family. The plan of care indicated that one staff member was to provide limited to extensive assistance to the resident for toileting. The DOC confirmed that the resident would be

given the option to try the home purchased pull-up style incontinent product.

F) Resident #045 was admitted to the home on an identified date in March, 2016. The DOC identified that this resident was using a pull-up style incontinent product. The plan of care indicated that the resident required the assistance of one staff with toileting. The resident actively participated in care tasks but needed step by step direction and physical assistance by staff during the toileting routine. PSW staff #107 and #116 confirmed that the family purchased pull-ups style incontinent product for the resident. The DOC confirmed that the home was now supplying the pull-up style incontinent product for the resident.

G) Resident #048 was admitted to the home on an identified date in May, 2016. The resident was identified by PSWs #107 and #116 as using a pull-up style incontinent product provided by family prior to a change in condition on an identified date in November, 2016 resulting from a physical injury. The resident then changed to requiring a brief. Pull-up style incontinent products were found in the resident's closet on an identified date in November, 2016.

H) Resident #047 was admitted to the home on an identified date in December, 2015. Interview with PSWs #116 and #107 confirmed that the resident currently wore a pull-up style incontinent product provided by family. The plan of care for the resident indicated that family supplied the incontinence products and staff were to be informed when running low so family could be called. Interview with the resident confirmed that they preferred a pull-up style product and they had not been offered an option of using a pull-up style product provided by the home. The DOC reported that the resident would be given the option to try the home purchased pull-up style incontinent product.

The DOC confirmed that the brand of the pull-up style incontinent product was insignificant and that the home should have provided the residents with a range of continence care products that, (i) were based on their individual assessed needs, (ii) properly fit the residents, (iii) promote resident comfort, ease of use, dignity and good skin integrity, (iv) promote continued independence wherever possible, and (v) were appropriate for the time of day, and for the individual residents' type of incontinence. The DOC also confirmed and provided the Long-Term Care Homes Inspector with a list of the above residents who would be reimbursed for the cost of the pull-up style incontinent products purchased by the families to date (including reimbursement amounts). The DOC confirmed that going forward the home would provide and purchase a pull-up style incontinent product to assessed residents. [s. 91. (4)]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

**Specifically failed to comply with the following:**

**s. 50. (2) Every licensee of a long-term care home shall ensure that,**
**(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,**
**(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,**
**(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,**
**(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and**
**(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff as evidenced by:

Resident #041 was admitted to the home on an identified date in August, 2016 with two identified areas of altered skin integrity. As confirmed with the DOC, the two identified areas were not reassessed until almost one month later on an identified date in September, 2016 when the wounds had deteriorated. The skin assessment completed on an identified date in September, 2016 indicated that both areas had deteriorated and a new area of altered skin integrity was identified. The home failed to ensure that the resident exhibiting altered skin integrity had been reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

***Additional Required Actions:***

***CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with as evidenced by:
Ontario Regulation 79/10 section 131 (6). Where a resident of the home is permitted to administer a drug to himself or herself under subsection (5), the licensee shall ensure that there are written policies to ensure that the residents who do so understand, (a) The use of the drug; (b) the need for the drug; (c)the need for monitoring and documentation of the use of the drug; and (d) the necessity for safekeeping of the drug by the resident where the resident is permitted to keep the drug on his or her person or in his or her room under subsection (7).

The home's policy and procedures Self-Administration of Medication #LTC-WQ-ON-200-06-20, revised November 2014 was reviewed and it included: "Residents who self-administer medication must store the medication in a locked safe location away from other residents." It also included: "Thereafter registered staff should review, audit and document on a weekly basis a resident's ability to self-administer their medications."
The record of resident #034 was reviewed and it was noted that the resident would self administer medications. Not all weekly documentation of the resident's ongoing ability to self-administer their medications were found in the resident's record.
The DOC was interviewed and confirmed that the home's Self-Administration of Medication policy and procedures were not followed as the resident did not keep their medications in a locked safe location away from other residents and weekly assessments of the resident's ongoing ability to self-administer were not always documented as per the policy and procedures. DOC also reported that resident no longer self-administers medications. [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 that 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, (b) is complied with in respect to medication self-administration:***
***O. Reg79/10 131 (6) Where a resident is permitted to administer a drug to himself or herself under subsection (5), the licensee shall ensure that there are written policies to ensure that the residents who do so understand,***
***(a) the use of the drug;***
***(b) the need for the drug;***
***(c) The need for monitoring and documentation of the use of the drug; and***
***(d) the necessity for safekeeping of the drug by the resident where the resident is permitted to keep the drug on his or her person or in his or her room under subsection (7), to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home as evidenced by:

The records of residents #038 and #039 were reviewed including the progress notes and it was noted that on an identified date in October, 2016 residents #038 and #039 were involved in a physical altercation resulting in resident # 039 sustaining minor injuries. The home's records including the Critical Incident report were reviewed and contained

information as above.
The Director of Care (DOC) was interviewed and confirmed the accuracy of the information contained in the residents' records and the home's records.
The home failed to ensure that resident #039 was protected from physical abuse by resident #038. [s. 19. (1)]

2. The records of residents #037 and #035 were reviewed and it was noted that on an identified date in October, 2016 the residents were involved in a physical altercation after resident #035 entered the room of resident #037. The altercation resulted in the physical injury of resident #037. Resident #035 was noted to have a history of physically responsive behaviors towards other residents. The home's records were reviewed including the Critical Incident report and it contained information as above. A second Critical Incident report was also reviewed and it was noted that resident #035 was previously involved in a physical altercation with an identified resident #036 which did not result in physical injury.
Resident #037 was interviewed and reported that they were involved in a physical altercation with resident #035 which resulted in injury. The DOC was interviewed and confirmed residents #035 and #037 were involved in an altercation which resulted in the physically injury of resident #037.
The home failed to ensure that resident #037 was protected from physical abuse by resident #035. [s. 19. (1)]

3. The home's records including the Critical Incident report was reviewed and it was noted that on an identified date in June, 2016 resident #033 was verbally abused by a staff member. The records indicated that resident #034 reported to the home that when they did not complete a task they had previously completed the staff said they did not have time for this and that the resident was driving them crazy. The resident was noted to have been scared and upset. They did not want to see the staff again. The resident's record including the progress notes were reviewed and contained information as noted in the home's records. The resident was interviewed and confirmed the incident. The DOC was interviewed and confirmed the information as contained in the home's records.
The home failed to ensure that resident #034 was protected from verbal abuse by a staff member. [s. 19. (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 all residents including residents #034, #037 and #039 are protected from physical and verbal abuse by anyone, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

**Specifically failed to comply with the following:**

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**19. Safety risks. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident safety risks as evidenced by:

Observation of residents #049 and #050's bed systems identified that they had a mattress on their bed with raised sides. Interview with the DOC #001 and DOC #002 verified that each of the residents had a mattress with raised sides; indicated that the home referred to these surfaces as "raised-side" mattresses and that although the home had approximately 20 per-cent of these mattresses in the home, they were not the only style available for use.
A review of the residents' plans of care did not include an assessment of the residents with respect to the use of the raised-side mattresses; nor did it identify if the surface supported the residents with an activity of daily living; restricted their movement out of bed or any other safety risks associated with the use of the device. The use of the raised-side mattress was not included in either of the resident's plan of care.
Interview with DOC #001 and DOC #002 verified that the home did not assess residents for the use of raised-side mattresses, other than based on their cognitive status and that the plans of care were not based on an assessment of the residents' safety risks. DOC #001 and DOC #002 confirmed that current or any new residents in the home using this type of mattress would be individually assessed for safety risks. [s. 26. (3) 19.]

***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 plans of care of all residents including residents #049 and #050 must be based on, at a minimum, interdisciplinary assessment of the following: safety risks, with respect to the resident, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management**

**Specifically failed to comply with the following:**

**s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose as evidenced by:

The record of resident #030 was reviewed including progress notes, Medication Administration Record (MAR), Point of Care (POC) documentation and care plan. It was noted that the resident had a history of responsive behaviors and pain. They received an identified pain medication four times daily to manage pain. On an identified date in February, 2016, the resident fell, sustained injury and complained of pain. The resident complained of soreness later that day and received the scheduled dose of pain medication. The resident also complained of pain to an area of their body. One day after the fall the resident received an additional dosage of pain medication that was ordered to be administered as needed. This was noted to be effective. Two days following the fall, the resident complained of pain to an area of their body. The resident was offered pain medication and refused. Later that day the resident complained of pain and it was noted that staff would monitor. Three days after the fall, it was noted that the resident refused a treatment and stated that they were in too much pain to be turned or to be touched. The resident called the nurse and requested to go to the hospital. The resident was not able to describe exactly where the pain was and would not let the staff touch an identified extremity. The scheduled pain medication was given. The resident remained in bed for the shift. No swelling, bruising or redness were observed on the resident. The resident verbalized they were experiencing discomfort and the staff informed the resident that they had altered skin integrity as a result of the fall. Four days following the fall, the resident made no complaints of pain. Later that day, the resident was found on the floor in their room. The resident complained of increased pain and was hospitalized.
Documentation of an assessment of the resident's pain after the fall, using a clinically appropriate assessment instrument specifically designed for pain was not found in the resident's record.
PSWs #120 and #121 were interviewed and reported that on the day of the incident, the resident was in pain; did want to move and that they reported this to the registered staff.
Registered staff member was interviewed and denied being informed by the PSWs that the resident was in pain.
The home's records were reviewed and it was noted that the resident's family member reported to the home that the resident was in pain.
The DOC was interviewed and confirmed that after resident #030 fell, they were not assessed using a clinically appropriate assessment instrument specifically designed for pain, when their pain was not relieved by initial interventions. [s. 52. (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 when any resident including resident #030's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:**

**1. A change of 5 per cent of body weight, or more, over one month.**
**2. A change of 7.5 per cent of body weight, or more, over three months.**
**3. A change of 10 per cent of body weight, or more, over 6 months.**
**4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months
4. Any other weight change that compromises their health status

Resident #007 had an admission weight recorded as a certain number of kilograms (kg) on an identified date in April, 2016. Subsequent identified monthly weights from May, 2016 to October, 2016 were noted in the resident's record.
The October, 2016 weight represented a change of over 10 per cent of body weight, or more, over six months when compared to the admission weight. No documentation was found in the resident's record indicating that this weight change was addressed.
Interview with the DOC #001 and DOC #002 confirmed that the expectation of the home would be that a referral be made to the Registered Dietitian and that the resident's weight change assessed within two weeks of the noted change. It was confirmed that the resident with a weight change of 10 per-cent of body weight, or more over six months was not assessed using an interdisciplinary approach, and that actions were not taken and outcomes evaluated. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all residents including resident #007 with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated: 1. A change of 5 per cent of body weight, or more, over one month. 2. A change of 7.5 per cent of body weight, or more, over three months. 3. A change of 10 per cent of body weight, or more, over 6 months. 4. Any other weight change that compromises the resident's health status, to be implemented voluntarily.***

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service**

**Specifically failed to comply with the following:**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who require assistance as evidenced by:

The lunch meal was observed in an identified home area on an identified date in November, 2016. The person who was feeding resident #040 was speaking in an inappropriate tone and feeding in an inappropriate manner. The person feeding resident #040 was later identified as a home volunteer. The volunteer was also observed to apply physical pressure to an identified body part of the resident.
Discussion with the Administrator and Volunteer Coordinator confirmed that the home's policy was to train their volunteers on safe feeding techniques; that these techniques had not been followed for this resident and that this volunteer would no longer be feeding residents in the home. [s. 73. (1) 10.]

***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 home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist all residents including resident #040 with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.***

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**WN #9: 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. (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 resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary as evidenced by:

The plan of care for resident #005 indicated that the resident was to be provided an identified number of millimeters (ml) of a beverage three times a day (TID) at each meal. During the observed lunch meal on an identified date in November, 2016, the resident was not provided with the beverage as per the plan of care. Interview with registered staff #100 confirmed that the resident's needs had changed and the resident no longer received the beverage at meals and the plan of care should have been changed. [s. 6. (10) (b)]

2. The plan of care for resident #009 indicated that staff were to ensure that the resident turned and positioned in bed with staff assistance at least every two hours (q2h) to decrease risk of skin breakdown. Interview with the DOC and PSW #109 confirmed that the resident was checked during the night but not woken up and repositioned. It was reported that the resident was presently independent with repositioning during the night. The DOC and PSW #109 confirmed that the plan of care had not been reviewed and revised when the resident's care needs had changed or care set out in the plan was no longer necessary. [s. 6. (10) (b)]

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**WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with as evidenced by:

The home's policy and procedures Abuse Allegations and Follow-Up #LTC-CA-WQ-100-05-02 revised July 2016 was reviewed and included: All persons who have reasonable grounds to suspect the occurrence of abuse are obligated to immediately report the suspicion and the information upon which it is based to regulatory bodies including the Ministry of Health and Long-Term Care (MOHLTC) - Director.
The records of residents #035 and #037 were reviewed. It was noted that on an identified date in October, 2016 resident #035 were involved in a physical altercation which resulted in physical injury to resident #037. The home's records including the Critical Incident report were reviewed and contained information as above. The DOC was interviewed and confirmed that the incident occurred on an identified date in October, 2016 and was reported to the MOHLTC 33 days later in November, 2016. They also confirmed that the home's abuse policy was not complied with as the alleged abuse incident was not immediately reported to the MOHLTC as per the home's policies and procedures. [s. 20. (1)]

**Issued on this 24th day of February, 2017**

**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**

**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

**Ministére 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

**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

## Public Copy/Copie du public

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|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | MELODY GRAY (123), CAROL POLCZ (156) |
| **Inspection No. / No de l'inspection :** | 2016_215123_0014 |
| **Log No. / Registre no:** | 031363-16 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Feb 22, 2017 |
| **Licensee / Titulaire de permis :** | Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner<br>100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1 |
| **LTC Home / Foyer de SLD :** | Chartwell Willowgrove Long Term Care Residence<br>1217 Old Mohawk Road, ANCASTER, ON, L9K-1P6 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Natasha Murray |

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.O. 2007, c.8, s. 91. (4) A licensee shall not accept payment from or on behalf of a resident for anything that the licensee is prohibited from charging for under subsection (1) and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee's behalf. 2007, c. 8, s. 91. (4).

**Order / Ordre :**

A licensee shall ensure that the home does not accept payment from or on behalf of a resident for anything that the licensee is prohibited from charging for under subsection (1) and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee's behalf; specifically for continence care supplies or products. 2007, c. 8, s. 91. (4).

**Grounds / Motifs :**

1. This Order is being issued based on the application of the factors of severity (2), scope (2) and compliance history of (2), in keeping with s. 299 (1) of the Regulation. This is in respect to the severity of harm or risk of harm to residents, the scope of the harm or risk of harm to the residents and the home's history of non-compliance.

The licensee failed to ensure that they did not cause or permit anyone to make a charge or accept such a payment on the licensee's behalf.
Ontario Regulation 79/10 section 245 paragraph 1 identified the following:
"The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act: 1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from, i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and ii. the Minister under section 90 of the Act".
The licensee received funding from the local health integration network under section 19 of the Local Health System Integration Act, 2006, for goods and services funded by the local health integration network under their service

accountability agreement for continence care supplies. The Long Term Care Home (LTCH) Policy, LTCH Required Goods, Equipment, Supplies and Services, dated July 1, 2010, identified that:
"The licensee must provide the following goods, equipment, supplies and services to long-term care (LTC) home residents at no charge, other than the accommodation charge payable under the Long-Term Care Homes Act, 2007 (LTCHA), using the funding the licensee receives from the Local Health Integration Network under the Local Health System Integration Act, 2006 (LHSIA) or the Minister under the LTCHA or accommodation charges received under the LTCHA.
2.1 Required Goods, Equipment, Supplies and Equipment
2.1.2 Continence Management Supplies
Continence management supplies including, but not limited to:
a. A range of continence care products in accordance with section 51 of the Regulation under the LTCHA".
A pull up style incontinent product must be provided as part of the range of continence care products to be provided at no charge by the home The licensee permitted the resident's representative to make a charge or accept a payment on the licensee's behalf for continence care products, which they received funding from the local health integration network under their service accountability agreement.

A) Resident #006 was admitted to the home on an identified date in January, 2016. The plan of care for the resident indicated that they wore a pull-up style continence management product and the home was to notify family when the resident needed more incontinent products. The resident required one staff to provide extensive assistance with toileting but was able to participate. Interview with the Personal Support Worker (PSW) Coordinator and the Continence Product Lead confirmed that the resident was suitable for the pull-up style product. PSW #116 and #107 confirmed that the resident currently wore a pull-up style incontinent product. The Director of Care (DOC) confirmed that the home was now supplying the product for the resident.

B) Resident #042 was admitted to the home on an identified date in May, 2014. The plan of care for the resident indicated that the resident wore a pull-up style incontinent product that the family was to provide. The plan indicated that one staff was to provide supervision with toileting; limited assistance if fatigued and the resident would direct staff to provide assistance. PSWs #116 and #107 confirmed that the resident currently wore a pull-up style product. Interview with

the resident confirmed that their family provided the pull-up style incontinent product; that they had never been given an option of trying a pull-up style product provided by the home and they would like to try them. The DOC confirmed that the resident will be given the option to try a pull-up style product provided by the home.

C) Resident #046 was admitted to the home on an identified date in February, 2015. PSW #117 reported that the resident had worn a pull-up style incontinent product provided by family. Pull-up style incontinent products were found in the resident's room. However, staff reported that the resident recently had changed to using a brief and no longer used the pull-up style product. The plan of care indicated that the resident was frequently incontinent but was able to recognize the urge to void most of the time. The plan indicated that the resident required assistance with toileting. One to two staff were to provide limited to extensive assistance for toileting. At times, the resident was able to be toileted by one staff, other times if resistive, two staff were needed. The DOC confirmed that the resident no longer used the pull-up style product.

D) Resident #043 was admitted to the home on an identified date in November, 2012. The DOC confirmed that the resident had been wearing pull-up style incontinent product provided by the family but was now using a brief style incontinence product. The plan of care for the resident indicated that the resident was frequently incontinent and required assistance with toileting. Interview with PSW #119 confirmed that the resident used to wear a pull-up product as of two to three weeks ago but was now using a brief.

E) Resident #044 was admitted to the home on an identified date in June, 2014. The plan of care for the resident indicated that the resident required assistance with toileting and wore a pull-up product which was supplied by their family. PSW #118 confirmed that the resident used a pull-up style incontinent product supplied by the family. The plan of care indicated that one staff member was to provide limited to extensive assistance to the resident for toileting. The DOC confirmed that the resident would be given the option to try the home purchased pull-up style incontinent product.

F) Resident #045 was admitted to the home on an identified date in March, 2016. The DOC identified that this resident was using a pull-up style incontinence product. The plan of care indicated that the resident required the assistance of one staff with toileting. The resident actively participated in care

tasks but needed step by step direction and physical assistance by staff during the toileting routine. PSW staff #107 and #116 confirmed that the family purchased pull-up style incontinent product for the resident. The DOC confirmed that the home was now supplying the pull-up style incontinent product for the resident.

G) Resident #048 was admitted to the home on an identified date in May, 2016. The resident was identified by PSW #107 and #116 as using a pull-up style incontinent product provided by family prior to a change in condition on an identified date in November, 2016 resulting from a physical injury. The resident then changed to requiring a brief. Pull-up style incontinent products were found in the resident's closet on an identified date in November, 2016.

H) Resident #047 was admitted to the home on an identified date in December, 2015. Interview with PSW #116 and #107 confirmed that the resident currently wore a pull-up style incontinent product provided by family. The plan of care for the resident indicated that family supplied the incontinence products and staff were to be informed when running low so family could be called. Interview with the resident confirmed that they preferred a pull-up style product and they had not been offered an option of using a pull-up style product provided by the home. The DOC reported that the resident would be given the option to try the home purchased pull-up style incontinent product.

The DOC confirmed that the brand of the pull-ups was insignificant and that the home should have provided the residents with a range of continence care products that, (i) were based on their individual assessed needs, (ii) properly fit the residents, (iii) promote resident comfort, ease of use, dignity and good skin integrity, (iv) promote continued independence wherever possible, and (v) were appropriate for the time of day, and for the individual resident's type of incontinence.
The DOC also confirmed and provided the Long-Term Care Homes Inspector with a list of the above residents who would be reimbursed the cost of the pull-up style products purchased by the families to date (including reimbursement amounts). The DOC confirmed that going forward the home would provide and purchase a pull-up style product to assessed residents. (156)

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

**Ministére 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

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Mar 08, 2017

**Order # / Ordre no :** 002

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(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 ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

**Order / Ordre :**

The licensee shall ensure that all residents including resident #041 who are exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, are reassessed at least weekly by a member of the registered nursing staff.

**Grounds / Motifs :**

1. This order is being issued based on the application of factors of severity (3), scope (1), in keeping with s. 299. (1) of the Regulation. This is in respect to severity of harm or risk of harm to residents, the scope of harm or risk of harm to residents and the home's history of non-compliance.

The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff as evidenced by:

Resident #041 was admitted to the home on an identified date in August, 2016 with multiple areas of altered skin integrity. As confirmed with the DOC, these areas were not reassessed until almost one month later on an identified date in September, 2016 when the wounds had deteriorated. The skin assessment completed on an identified date in September, 2016 indicated that both areas had deteriorated and a new area of altered skin integrity was identified. The home failed to ensure that the resident exhibiting altered skin integrity had been reassessed at least weekly by a member of the registered nursing staff. (156)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Feb 28, 2017

## 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

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
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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
Ontario, ON
M5S-2B1
Fax: 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 22nd day of February, 2017**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** MELODY GRAY

**Service Area Office /**
**Bureau régional de services :** Hamilton Service Area Office