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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 19, 2018	2018_543561_0009	013960-18	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

DARIA TRZOS (561), YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 20, 21, 22, 25, 26, 27, 28, and July 3, 4, 2018.

The following inspections were completed concurrently with this Resident Quality Inspection (RQI):

Follow Up Inspection with the following log number:
009834-18 - related to abuse and neglect,

Complaint Inspection with the following log number:
009779-18 - related to care issues and positioning

Critical Incident (CI) inspections with the following log numbers:
007374-18 - related to falls
008627-18 - related to falls

During the course of the inspection, the inspector(s) spoke with the Administrator, Directors of Care (DOCs), Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Registered Dietitian (RD), Resident Support and Services Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Family Council Representative, Resident Council Representative, residents and family members.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, reviewed relevant documents including but not limited to, clinical records, policies and procedures, internal investigation notes, training records and meeting minutes.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

2 WN(s)
1 VPC(s)
0 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.O. 2007, c.8 s. 19. (1)	CO #001	2018_542511_0005	632

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 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.

The manufacturer's instruction for the application of a restraint device, from Personal Safety Products, revised February 18, 2016, was reviewed and provided instruction on correct application of the restraint device.
The instructions for the use of the device used in the home were also posted on the units.

Resident #007 was observed by LTCH Inspector #561 during stage one of the inspection, and the restraint device was observed to be incorrectly applied.

PSW #106 was called by LTCH Inspector #561, and acknowledged that the device was incorrectly applied. PSW #106 was aware of the correct application of the restraint and proceeded to readjust the device. LTCH Inspector #561 interviewed RPN #105 and they acknowledged that the device was incorrectly applied. RPN #105 ensured that the device was correctly applied.

On an identified day during inspection, LTCH Inspector #561 observed resident #014 in the television room and a device was observed incorrectly applied. RN #114 acknowledged that the device was incorrectly applied. The RN was unable to fix the device.

The ADOC and the DOC #2 were interviewed and stated that the staff in the home had placed a note in the maintenance binder on on an identified date in 2018 that resident #014's device required repair. In the meantime resident #014 was closely monitored. The DOC reported to LTCH Inspector #561 that the device was later fixed by the maintenance staff. LTCH Inspector #561 observed resident #014 and the device was correctly applied.

The licensee failed to ensure that the restraints were applied for resident #007 and #014 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 the physical device is applied in accordance with the manufacturer's instructions, to be implemented voluntarily.

WN #2: 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. (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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 there was a written plan of care that set out the planned care for the resident.

A complaint was submitted to the Ministry of Health and Long Term Care related to resident #010’s care.
Resident #010 was observed for periods during this inspection. The clinical records were reviewed and the home had put a plan in place with an intervention.
PSW #124 was interviewed and acknowledged that this intervention was in place. RPN #131 was interviewed by LTCH Inspector #561 and acknowledged that this intervention

was in place.
The current written plan of care and kardex were reviewed and this intervention was not included in the written plan of care. RPN #131 stated that the written plan of care should have been updated to include this intervention.

Interviewed the Administrator and was aware of the intervention that was put in place and acknowledged that the written plan of care should have included the new intervention.

The licensee failed to ensure that the written plan of care for resident #010 set out the planned care as requested by the family.

This area of non-compliance was identified during a Complaint Inspection, log #009779-18, conducted concurrently during the Resident Quality Inspection (RQI) [s. 6. (1) (a)]

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 the resident's care needs changed or when care set out in the plan was no longer necessary.

Resident #009 was observed receiving an identified type of assistance during meal service by staff #133. The plan of care for resident #009, specifically the written care plan, indicated that the resident required a different type of level of assistance eating. MDS Quarterly Review Assessment, indicated in “Section G: Physical Functioning and Structural Problems” that for eating the resident was coded to require the assistance as observed by LTCH Inspector. Review of “Activities of Daily Living (ADL) functional /rehab potential Resident Assessment Protocol (RAP)” profile, indicated the level of assistance to be as in the written care plan. Staff #109 and #113 were interviewed and indicated that resident #009 required the level of assistance with eating as observed by LTCH Inspector. Resident Assessment Instrument (RAI) Co-ordinator confirmed that the resident was reassessed and the plan of care was not reviewed and revised when the resident had a change in the level of assistance, which was acknowledged by the DOC #2.

The home did not ensure that resident #009 was reassessed and the care plan was reviewed and revised at any other time when the resident’s requirement for assistance with eating changed. (632) [s. 6. (10) (b)]

Issued on this 27th day of August, 2018

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

Original report signed by the inspector.