Ontario

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

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

Hamilton District
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Hamilton, ON, L8P 4Y7
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Original Public Report

Report Issue Date: May 30, 2023	
Inspection Number: 2023-1405-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc.	
Long Term Care Home and City: Chartwell Willowgrove Long Term Care Residence, Ancaster	
Lead Inspector Barbara Grohmann (720920)	**Inspector Digital Signature** Barbara Grohmann 2023.05.31 08:45:31 -04'00'
Additional Inspector(s) Patrishya Allis (000762) Inspector Carla Meyer (740860) was present during the inspection	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: May 17, 19, 23-25, 29, 2023

The following intake was inspected in this complaint inspection:

- Intake: #00018964 related to continence care.

The following intake was inspected in this Critical Incident (CI) inspection:

- Intake: #00001228 [CI: 2921-000024-22] related to fall prevention and management.

The following intakes were completed in this inspection: intake: #00005930, CI: 2921-000004-22; intake: #00012178, CI 2921-000026-22; intake: #00017292, CI 2921-000002-23; and intake: #00084195, CI 2921-000008-23 were related to falls prevention and management.

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

Continence Care
Falls Prevention and Management
Infection Prevention and Control

INSPECTION RESULTS

Non-Compliance Remedied

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

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

The bladder function and bowel function focuses of a resident's care plan directed staff to provide incontinence products as outlined on the continence product list. A personal support worker (PSW) provided the continence product list for the unit and stated that they did not typically work there but believed that was the correct list. A review of the product list showed that the resident was not on it. A second continence product list was found on the unit and the resident was on that list.

Two other PSWs who regularly worked on the unit reviewed the two documents and identified which list was the current one. They agreed that the two different lists may be confusing for staff unfamiliar with the unit and/or the residents. The PSW coordinator acknowledged that each unit should have only the most current continence product list and stated that they would correct that situation. On May 23, 2023, only one continence product list was found on the unit, and it included the resident.

Sources: resident's clinical records, unit Continence Product lists; observations; interviews with the PSW Coordinator and other staff.
[720920]

Date Remedy Implemented: May 23, 2023

WRITTEN NOTIFICATION: Directives by Minister

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that they carried out every operational or policy directive that applied to the home, which included Minister’s Directives.

In accordance with the Minister's Directive, COVID-19 Guidance Document for Long-Term Care Homes in Ontario, the licensee was required to complete Infection Prevention and Control (IPAC) audits every two weeks when the home was not in an outbreak.

Rationale and Summary
A review of completed COVID-19 Self-Assessment Audit Tools identified that an audit was completed in April 2023 and the next was in May 2023. As the home was not in an outbreak at that time, to maintain a schedule of every two weeks, another audit should have been completed in April 2023.

The IPAC lead acknowledged they were aware the audit tool was to be completed every two weeks. They stated that they were away and had arranged for the Director of Care (DOC) to complete it. Upon their return, they learned that the DOC was no longer working at the home and that the audit had not been completed. The IPAC lead explained that instead of completing one when they returned, they decided to follow their previously determine schedule and performed the next audit in May 2023.

Failure to complete COVID-19 Self-Assessment Audit Tools as per the required schedule may have impacted the home's ability to assess whether their IPAC practices met the minimum IPAC requirements under the applicable legislation.

Sources: COVID-19 Self Assessment Audit Tools (April and May 2023), Minister's Directive: COVID-19 response measures for long-term care homes (August 30, 2022), COVID-19 guidance document for long-term care homes in Ontario (April 3, 2023); interview with the IPAC lead. [720920]

WRITTEN NOTIFICATION: Care Plans and Plans of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 10.

The licensee has failed to ensure that a resident's plan of care included falls focus and interventions post fall.

Rationale and Summary
A resident's clinical records indicated that they were low to moderate risk for falls on admission. Their admission care plan did not include their risk for falls, falls focus or falls prevention interventions.

When the resident had a fall, their care plan was not revised to include a fall focus or interventions.

The resident had a second fall which resulted a hospitalization and significant change. Their care plan was not updated to include falls prevention interventions until they returned from the hospital.

The Assistant Director of Care (ADOC), a registered nurse (RN), and Resident Assessment Instrument (RAI) Coordinator acknowledged that the resident was at risk for falls and that their care plan should have had a fall focus and/or precautionary interventions upon admission and after the first fall.

Failure to update and revise the care plan to reflect the needs of the resident may have resulted in increased risk for falls due to the lack of direction for staff to implement appropriate interventions to reduce the risk of falls.

Sources: resident's clinical records, interviews with RAI Coordinator, ADOC, and other staff. [000762]

WRITTEN NOTIFICATION: General Requirements for Programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that any actions taken with respect to a resident under the nursing and personal support services program, as required in FLTCA s. 11 (1), including interventions, were documented for a resident.

Rationale and Summary
A resident's care plan indicated that they were incontinent of both bladder and bowel, required a brief and extensive assistance with toilet use. Their task list indicated that staff were to document bladder continence, bowel movements and toilet use every shift (day, evening and night) at a minimum.

A PSW stated that they have to document continence care at least once a shift and are expected to document multiple entries, if needed, to accurately capture product usage.

Point of Care (POC) documentation was reviewed for one month and identified that documentation was not completed for bladder continence for eight shifts, bowel moments for seven shifts and toilet use for eight shifts.

Failure to document task as required may have resulted in inconsistent care.

Sources: resident's clinical records; interviews the acting DOC and staff. [720920]