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
Jan 25, 2017	2016_413500_0012	007458-16	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 Woodhaven Long Term Care Residence
380 Church Street MARKHAM ON L6B 1E1

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

NITAL SHETH (500), DEREGE GEDA (645), KAREN MILLIGAN (650), VALERIE JOHNSTON (202)

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): October 3, 4, 5, 6, 7, 11, 12, 13, 14, 17, 18, 19, 20, 21, 24, 25, 26, 2016.

The following intakes were inspected concurrently during this RQI:

- Critical Incident (CI) Intakes related to staff to resident abuse: #029775-15, #017065-16, #027848-16,
- Critical Incident (CI) Intakes related to falls #025800-16, #026973-16, #026866-16, #028731-16,
- Critical Incident (CI) Intakes related to injury #028651-16, #028761-16
- Critical Incident (CI) Intakes related to improper treatment #019038-16
- Complaint Intakes related to staff to resident abuse: #006198-15
- Complaint Intake related to personal support services #004739-14, #032685-15
- Complaint Intake related to pest control #015725-15
- Follow-up order Intake related to duty to protect: #005635-16, and #023778-16.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Resident Support Service Manager, Physiotherapist, Building Manager, Dietary Supervisor, Environmental Service Manager (ESM), House-keeping Manager, Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Recreation Aides, Dietary Aides, Personal Care Aides (PCAs), Agency Personal Care Aides (PCAs), President of the Residents' Council, Active Members of the Family Council, Residents, and Family Members.

During the course of the inspection, the inspectors conducted observations of residents and home areas, medication administration, meal service delivery, infection prevention and control practices, reviewed clinical health records, staffing schedules/assignments, minutes of Residents' Council and Family Council meetings, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **5 WN(s)**
- **4 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	2016_405189_0003	500
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #001	2015_168202_0024	202

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.O. 2007, c.8, 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

A review of CIS revealed residents #025, #026, and #027 alleged PCA #146 and #111 had been disrespectful towards resident during the meal service in 2016. All three residents were upset and stated that this behaviour was ongoing and they were fed up.

Interview with resident #025, and #026 confirmed the above mentioned information and indicated that they felt disrespected and upset because of this behaviour from PCA #146, and #111.

Interview with resident #027 who was also involved in making the allegation to the above mentioned PCAs as per the CI revealed that he/she did not remember the incident.

The inspector could not complete interview with PCA #111 because he/she was no longer working with the home and PCA #146 denied the allegation in an interview with the inspector.

A review of the home's investigation revealed that PCA #111 was disciplined as a result of violating Residents' Bill of Rights and PCA #146 was terminated from the home due to being disrespectful, unprofessional and violating Residents' Bill of Rights.

Interview with ADOC #114 revealed that PCA #111, and #146 were disciplined as a result of the investigation. [s. 3. (1) 1.]

2. A review of CIS revealed that resident #026 and #028 approached PCA #115, and reported concerns about PCA #146 being disrespectful. Resident #028 reported to PCA #115 that PCA #146 called him/her with an inappropriate term when he/she complained.

Resident #026 reported that PCA #146 talked in a superior manner, banged the shower chair to the wall and conducted an inappropriate behaviour at resident #026, without apologizing. Both residents were upset and in emotional distress. PCA #146 received disciplinary actions as a result of the investigation. A review of the CI did not reveal the dates when incidents actually occurred.

Interview with resident #026 revealed that PCA #146 was disrespectful to him/her and he/she felt upset about it. Resident #026 was unable to provide more detail about the incident.

Interview with resident #028 was not completed because the resident was discharged from the home.

Interview with PCA #115 revealed that, both residents #026 and #028 were cognitively alert and were very upset when reported about PCA #146. Both residents raised concerns on the same day and therefore, he/she reported it to the management. Both residents reported about PCA #146 being disrespectful to them. Resident #028 reported that PCA #146 called him/her in an inappropriate manner. Resident #026 reported PCA #146 behaved inappropriately at him/her without apologizing when PCA #146 banged a shower chair against the wall in the shower room. Resident #026 stated PCA #146 brought wrong order at meal times. PCA #115 indicated that PCA #146 speaks with a rude tone which can make the residents feel disrespected and results in some residents expressing displeasure with PCA's behaviour.

Interview with RPN #116 revealed that resident #028 reported PCA #146 used inappropriate terms for him/her and brought the wrong order for resident #026 at meal times.

Interview with RN #148 revealed that both residents raised concern about PCA #146 on the same day. Resident #028 reported PCA #146 provided care in a rough manner, calling him/her using inappropriate term. Resident #026 reported PCA #146 did not bring a meal tray for meal for him/her and PCA #146 was not gentle while providing care.

A review of PCA #146's employee file revealed ongoing disciplinary measures taken by the home. A review of the disciplinary action form revealed that PCA #146 was disciplined for disrespectful and harmful behaviour to residents. [s. 3. (1) 1.]

3. A review of CIS revealed that resident #023 reported to the home that PCA #146 was verbally abusive to him/her in 2015, during preparation for his/her transfer.

A review of resident #023's written plan of care revealed that resident #023 required two people assistance for transfers. Resident #023 was alert and oriented.

A review of the progress note in 2015 revealed that resident reported a concern related to transfer that involved PCA #146. The progress notes indicated the resident was upset and did not feel comfortable with the manner the transfer was conducted.

Interview with resident #023 revealed that PCA #146 and student PCA #112 were assisting him/her for a transfer in 2015. PCA #146 was disrespectful to the resident and his/her tone of voice was rude. PCA #146 grabbed a controller of the device from student PCA #112's hands, while student PCA #112 tried to stop transferring because resident #023 was not fully secured with the identified device.

The Inspector was unable to interview student PCA #112, as the student PCA #112 did not respond to the inspector's voicemail.

The Inspector was unable to interview PCA #146 as PCA #146 is no longer working with the home.

A review of student PCA #112's written statement revealed that the resident called out from his/her room and student PCA #112 approached the resident and assisted him/her. The resident mentioned feeling tired and wanted to sleep. Student PCA #112 prepared the resident for a transfer and waited for PCA #146. PCA #146 approached the room, and he/she demonstrated anger towards the resident and they were hostile to one another.

Interview with RPN #113 revealed that he/she heard some sounds from the resident's room and went to the room. Resident #023 reported that PCA #146 was verbally abusive to him/her. RPN #113 indicated that, once he/she approached resident #023's room, student PCA #112 exited from the room and the resident was transferred safely by PCA #146 and RPN #113.

Interview with ADOC #114 revealed that PCA #146 was disciplined and removed from the resident's care as a result of being disrespectful to the resident.

Interview with DOC revealed that PCA #146 was terminated.

Interview with ADOC #114 revealed that PCA #146 was found disrespectful to resident #026, and #028 and was disciplined as a result of the investigation. [s. 3. (1) 1.]

4. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: every resident has the right not to be neglected by the licensee or staff.

A review of the CI report revealed that resident #021 reported to his/her family member that the night PCA #100 did not assist him/her when the resident rang the call bell for assistance. PCA #100 came in the room, when the call bell was ringing, removed the bed cover from the resident and stood back and watched the resident struggling to get up but did not assist. After the home's investigation the PCA was suspended and re-educated on Resident Abuse; Residents' Rights will be completed prior to her return to work.

A review of the resident's written care plan and Kardex, revealed that the resident required assistance. Provide one person assistance and constant guidance when feeling unwell. The resident can perform some tasks, but needs to help with proper care to maintain safety.

The inspector was unable to interview the resident and the family member as the resident was discharged.

A review of the home's response letter to the family member revealed that a full investigation was completed and PCA #100 will be given appropriate discipline and re-education on resident abuse and residents' rights prior to his/her return to work.

A review of the home's investigation record revealed PCA #100's disciplined neglecting resident #021.

Interview with RPN #104 revealed that resident #021 and a few other residents had raised concerns about PCA#100 and the manner he/she treated residents. Resident #021 voiced a concern that PCA#100 did not provid the resident assistance. RPN #104 considered the lack of assistance to be neglect.

Interview with RPN #101 revealed that resident #021's family member raised a concern related to PCA #100's failure to provide resident #012 the assistance he/she required . The family member indicated he/she felt this was neglect.

Interview with ED and DOC revealed that they were not working in the home at the time of the incident; however, based on the records and the home's investigation, PCA #100 was disciplined for neglecting resident #021. [s. 3. (1) 3.]

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 following rights of residents are fully respected and promoted:
- every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity
- every resident has the right not to be neglected by the licensee or staff, to be implemented voluntarily.

WN #2: 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 comply with the policy on Pest Control-Bedbug Protocol.

Inspection of the anonymous complaint received by the Ministry of Health and Long-term Care (MOHLTC) in 2015 revealed that the home has put a wrapped bedbug infested mattress in the walk-in kitchen food freezer.

The home policy # CA-ALL-500-03-06, entitled "Pest Control- Bedbug Protocol", revised on January 2015, stated that if any presence of bed bugs are suspected or confirmed staff are expected to contact supervisor immediately and provide a description and location of sighting of the bedbug, follow the direction provided from supervisor, use PPEs, and to contact pest control ask for immediate service, items are to be completely wrapped and moved as soon as possible.

The procedure and manual of the Pest Control-Bedbug protocol does not direct staff to store bed bugs infested mattress in the kitchen walk-in freezer that contains residents' food.

Interview with Cook #130, confirmed that a bed bug infested mattress wrapped with a plastic bag was kept in the kitchen freezer that contains food last year. He/she stated at the beginning of his/her shift he/she observed that there was a bedbug infested mattress in the kitchen Cook #130 spoke with the supervisor and maintenance personnel and threw the mattress outside. Cook #130 re-iterated that this kind of practice never happened at the home prior to this incident.

Interview with Environmental Service Manager (ESM) #128, confirmed that the bedbug infested mattress was stored in the fridge for several hours. He/she reiterated and

confirmed that placing an infested mattress in the kitchen freezer that contains food is not acceptable as it is not indicated in the home's policy. ESM #128 stated that the mattress was stored in the freezer approximately for several hours before it was thrown out.

Interview with the ED, confirmed that the previous Housekeeping Manager #140 put the bed bug infested mattress in the kitchen freezer for a few hours before they decided to throw it out. ED stated he/she agreed with the decision at the time because the previous Housekeeping Manager #140 had informed him that the pest control company had suggested the mattress be placed in the freezer.

The home has a clear policy on pest control specifically on bedbug containment and treatment. ED confirmed that it is not the home policy to put a bed bug infested mattress in the freezer that contains food and this policy was not followed by Housekeeping Manager #140. [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 staff comply with the policy on Pest Control-Bedbug Protocol, to be implemented voluntarily.

WN #3: 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 has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A review of CIS revealed that resident #023 reported to the home that he/she was not properly secured during a transfer conducted by PCA #146.

A review of resident #023's written plan of care revealed that the resident required two

people assistance for transfers. Resident #023's was alert and oriented.

A review of the progress note revealed that resident reported a concern related to transfer that involved a specific PCA. The progress notes indicated the resident was upset and did not feel comfortable with the manner the transfer was conducted.

Interview with resident #023 revealed that PCA #146 and student PCA #112 were assisting him/her with a transfer in 2015. PCA #146 was disrespectful to the resident and his/her tone of voice was rude. PCA #146 grabbed a controller for the device from student PCA #112's hands, while student PCA #112 tried to stop the device because resident #023 was not fully secured. The resident indicated that he/she felt insecure and scared. The nurse arrived because of the verbal conversations in the room, student PCA #112 left the room and the nurse and PCA #146 completed the transfer.

The Inspector was unable to interview student PCA #112, as the student PCA #112 did not respond to the inspector's voicemail.

The Inspector was unable to interview PCA #146 as PCA #146 is no longer employed by the home.

A review of student PCA #112's written statement revealed that the resident called out from his/her room and student PCA #112 approached the resident and assisted him/her. The resident mentioned feeling tired and wanted to sleep. Student PCA #112 prepared the resident for a transfer and waited for PCA #146. PCA #146 approached the room, and he/she demonstrated anger towards the resident and they were hostile to one another. PCA #146 continued to transfer when he/she tried to stop PCA #146 because the resident was not secured properly.

Interview with RPN #113 revealed that he/she heard some sounds in the room and went to the resident's room. The resident reported that PCA #146 was verbally abusive to him/her. RPN #113 indicated that, once he/she approached to the resident's room, student PCA #112 exited from the room and the resident was transferred by PCA #146 and RPN #113.

Interview with ADOC #114 revealed that PCA #146 was found doing unsafe transfer for resident #023 and disciplined as a result of the investigation. PCA #146 should have maintained a safety of the resident and use assistance from another PCA and not just

with the student help. As per the home's policy two staff should have been assisting the resident for using a device to transfer him/her. [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 to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident has been assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The home submitted a CIS in 2016, indicating that resident #031 had been diagnosed with an injury after being sent to hospital following increased pain. During the home's investigation, it was reported that resident #031 had a fall in 2016 that had not been documented as having occurred.

A review of the home's falls prevention policy titled, Resident Falls, revised May 2016, defines a "fall" as any unintentional change in position where the resident ends up on the floor, ground or lower level. Registered staff have been directed to complete a Post Fall Analysis for any resident deemed high risk related to falls.

A review of resident #031's clinical records identified the resident as cognitively impaired, required two staff assistance and at high risk for falls. A review of the resident's progress notes indicated that the resident had a fall in his/her room and sustaining an injury. The notes further indicated that on an identified day the resident was found to have pain and swelling. The resident was sent to hospital for further assessment and returned to the home with an injury.

An interview with PSW #123 indicated that in 2016, he/she found resident #031 sitting on the floor resting against the wall. The PSW further indicated that he/she called PSW #125 and RPN #122 for further assistance and stated that the resident would not have been physically able to sit on the floor by him/herself and confirmed that the resident had fallen to the floor.

An interview with RPN #122 indicated that he/she had observed resident #031 sitting on the floor of his/her room and had assisted both PSW's #123 and #125 in standing the resident up from the floor. The RPN further indicated that he/she did not consider the resident to have fallen at this time and had assumed the PSW's had lowered the resident to the floor in order to provide safe care. The RPN stated that he/she did not document the incident or complete a post fall analysis of the un-witnessed fall because he/she assumed the resident had not fallen.

An interview with ADOC #114 indicated that registered staff are to complete a "Post Fall Analysis" for every resident that has fallen in the home and that the "Post Fall Analysis" is the home's clinically appropriate assessment tool specifically designed for falls. The ADOC further indicated that in 2016, when resident #031 had been found on the floor of his/her room by PSW #123, RPN #122 failed to identify that the resident had fallen and confirmed resident #031 had not received a post-fall assessment using a clinically appropriate assessment tool specifically designed for falls as required. [s. 49. (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 a resident has fallen, the resident has been assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #5: 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. (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).

Findings/Faits saillants :

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

A review of resident #022's written plan of care revealed an intervention to invite the resident and the significant other to attend recreational activities with the resident. An additional intervention indicated to invite and assist resident #022 to programs of interest.

An interview with the resident's family member revealed that he/she visits the resident almost every day and staff do not always invite the resident to attend recreational programs because the resident has a language barrier.

A review of the resident's attendance record for recreational program revealed,
- Based on the resident's attendance sheets for 2015, program #1 was offered three times in each month in 2015. The resident attended program #1 for three times only in 2015. The rest of the months the resident did not attend program #1. The resident did not attend program #1 for 9 months in 2015.

- The resident did not receive any program #2 in two months in 2015, and in 2016. Program #2 was offered two times each month based on the attendance sheet in both years.

- The resident did not attend program #3 in four months in 2015 and two months in 2016. Program #3 was conducted two times in each month as per the attendance sheet 2015 and 2016.

Interview with Recreational Aide #107, who provides programs on resident #022's floor, revealed that he/she does not always invite residents who have a language barrier to programs due to his/her understanding that those residents will not be able to participate in programs.

Interview with Recreational Aide #108, and Resident Support Service Manager revealed that all residents should be invited to all programs whether they have a language barrier or not or when a family member is visiting.

Interview with Resident Support Service Manager revealed that it is the home's expectation that recreation staff are expected to invite and offer residents an opportunity to attend programs of interest as indicated in their plan of care. [s. 6. (7)]

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Issued on this 26th day of January, 2017

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

Original report signed by the inspector.