Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 24, 2021	2021_919026_0004	013218-21, 013991-21, 015116-21	Critical Incident System

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
7070 Derrycrest Drive Mississauga ON L5W 0G5

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

JULIE DUNN (706026), JACK SHI (760)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 2, 3, 4, 5, and 8, 2021

Log # 013218-21, CIS report #2888-000027-21 was related to an alleged incident of staff to resident neglect and skin and wound care;
Log # 013991-21, CIS report #2888-000031-21 was related to an alleged incident of staff to resident improper care;
Log # 015116-21, CIS report #2888-000033-21 was related to an alleged incident of staff to resident improper care and medication.

During the course of the inspection, the inspector(s) spoke with Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Recreation Aide, Pharmacist, Physician, the Assistant Director of Care (ADOC), the Director of Care (DOC) and residents.

Inspector #732787 was present during this inspection.

During the course of the inspection, the inspector toured the home, observed Infection Prevention and Control (IPAC) practices, observed care activities on the units, reviewed relevant policies and procedures, reviewed the home's internal investigation notes and reviewed resident records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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	Légende 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. 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 a resident was protected from neglect by the licensee or staff.

According to Ontario Regulation 79/10 s. 5, neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A resident's family member noticed the resident's clothing item was soiled and reported it to the RPN on duty. The RPN assessed and discovered an alteration in skin integrity.

A PSW stated the resident slept wearing the clothing item and if it was clean, they would leave it when dressing the resident.

An RPN stated that they did not fully assess the resident when providing a treatment for the resident, and they did not do a head to toe check when doing a weekly assessment for a resident.

The DOC stated the expectations of the long-term care home are to change the clothing items when dressing residents. The DOC stated that a weekly assessment should include a head to toe assessment. The DOC stated that when providing a treatment, the staff should have noticed changes and taken action, and confirmed that they would consider this to be neglect.

Sources: Critical Incident Report, the resident's clinical record, interviews with PSW, RPN and DOC. [s. 19. (1)] (706026)

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 resident is protected from neglect, to be implemented voluntarily.

WN #2: 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 failed to ensure two residents were transferred safely after sustaining a fall.

A resident fell and sustained a minor injury. An RN stated they performed a manual lift transfer with a second staff present. The RN stated they would manually transfer residents if they do not observe any injuries to the resident at the time of their fall. The ADOC stated that unless a resident is able to get up themselves, staff should be using a mechanical lift to transfer the resident after a fall. The ADOC confirmed that manually transferring the resident after their fall was considered unsafe.

Sources: Resident's progress notes; Interviews with RN, ADOC and other staff. [s. 36.]

2. A Critical Incident report was submitted by the home regarding a resident's fall that resulted in an injury and transfer to hospital. At the time of the incident, the resident's care plan noted specific instructions for assistance with transfers. An RPN stated that they transferred the resident in an unsafe manner. The DOC stated this transfer was unsafe and may have increased the risk to the resident.

Sources: Resident’s progress notes and care plan; Interviews with RPN, DOC and other staff. [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 #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. 1. The licensee failed to ensure that a medication incident report was completed when they discovered a medication incident related to an RPN.

A Critical Incident report was submitted by the home regarding a medication incident involving an RPN.
A medication incident report was not presented to the inspector at the time of inspection.

The DOC clarified that a medication incident report was partially completed but not fully completed, and acknowledged that it should have been fully
completed when the home discovered the medication incident.

Sources: Critical Incident report, Interview with DOC and other staff. [s. 135. (2)] (760) [s. 135. (2)]

Issued on this 26th day of November, 2021

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

Original report signed by the inspector.