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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: February 27, 2023	
Inspection Number: 2023-1373-0003	
Inspection Type: Critical Incident System	
Licensee: Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc.	
Long Term Care Home and City: Chartwell Woodhaven Long Term Care Residence, Markham	
Lead Inspector Rita Lajoie (741754)	**Inspector Digital Signature** Rita Lajoie Digitally signed by Rita Lajoie Date: 2023.03.01 14:52:30 -05'00'
Additional Inspector(s) Angie M King (644)	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
January 27, 30, 31, February 2, 3, 6 - 9, 13, 2023 conducted on-site and February 14, 2023 conducted off-site.

The following intake(s) were inspected:

- Intake: #00001411 - related to misuse/misappropriation of resident's money
- Intake: #00001931 - related to resident to resident related to responsive behaviours.
- Intake: #00010787 - related to improper care of resident
- Intake: #00013796 - related to fall of resident

The following intakes were completed in the Critical Incidents Systems inspection:
Intake: #00002378, #00003796, #00006490, #00011708 - related to falls incidents.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: REPORTS OF INVESTIGATION

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee has failed to ensure the improper care of resident #003 was reported immediately to the Director.

Rationale and Summary
The home's Administrator received a written complaint from resident #003's Power of Attorney (POA), alleging injury to the resident by staff. The home submitted a Critical Incident System (CIS) report to the Director two days after the complaint was reported.

The Interim DOC acknowledged that the POA's complaint should have been reported to the Director immediately.

Failing to immediately report care of a resident to the Director put the resident at continued risk of harm.

Sources: CIS, interview with Interim DOC/Nursing Corporate Consultant.[644]

WRITTEN NOTIFICATION: LICENSEES WHO REPORT INVESTIGATIONS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 2. ii.

The licensee failed to ensure that reports made to the Director included the names of any staff members who were present at the incident.

Rationale and Summary
A review of CIS submitted to the Director, did not include the staff members who were present at the incident.

An interview with the interim DOC/Nursing Corporate Consultant confirmed in this report to the Director did not include the above-mentioned information.

There was low risk to resident when the licensee did not include the staff members names who were present at the incident.

Sources: CIS, interview with the interim DOC/Nursing Corporate Consultant. [644]

WRITTEN NOTIFICATION: LICENSEES WHO REPORT INVESTIGATIONS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1) 2. iii.

The licensee failed to ensure that reports made to the Director included the names of any staff members who responded to the incident.

Rationale and Summary
A review of CIS submitted to the Director did not include the staff members who responded to the incident.

An interview with the interim DOC/Nursing Corporate Consultant confirmed in this report did not include the above-mentioned information.

There was low risk to resident when the licensee did not include the staff members names who responded to the incident.

Sources: CIS, interview with the interim DOC/Nursing Corporate Consultant. [644]