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: October 31, 2023

Inspection Number: 2023-1373-0005

Inspection Type:
Complaint
Critical Incident

Licensee: Regency LTC Operating Limited Partnership, by it general partners, Regency Operator GP Inc. and AgeCare Iris Management Ltd.

Long Term Care Home and City: AgeCare Woodhaven, Markham

Lead Inspector	**Inspector Digital Signature**
AngieM King (644)	Angeli M King Digitally signed by Angeli M King Date: 2023.11.01 15:16:55 -04'00'

Additional Inspector(s)
Asal Fouladgar (751)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 20 - 22, 25-29, 2023
The inspection occurred offsite on the following date(s): September 25, 2023

The following intake(s) were inspected:

- An intake related to responsive behaviours and altercations.
- An intake related to falls prevention and management
- A complaint intake related to responsive behaviours.
- A complaint related fall prevention, neglect, continence and bowel management, missing clothes, plan of care, improper medication admin, staffing levels.

This Inspection was conducted concurrently with Inspection #2023-1373-0004.

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

Resident Care and Support Services
Continence Care

Skin and Wound Prevention and Management
Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

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 # remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that when the resident is reassessed that the plan of care is reviewed and revised when the care needs change.

Rationale and Summary
The Ministry of Long-Term Care (MLTC) received a complaint a resident personal care aid.
The resident's plan of care did not identify the resident's specific behaviour of their personal aids. They were observed on specific dates in September 2023, wearing their personal aids. Review of the resident's progress notes indicated that on a specific date in September 2023, a specific personal aid was missing and was found in a beverage. The resident's Minimum Data Set (MDS) Trigger Listing & Resident Assessment Protocols (RAP) Information with a specific Assessment Reference Date (ARD), indicated they frequently removed and misplaced their personal aid.

Several staff stated in interviews that they were aware the resident would remove and hide their personal aid on multiple occasions. In addition, when it was noted the resident was not wearing them, staff would search for the missing personal aid. A staff recalled the resident had removed their personal aid and they were found in the resident's undergarment; the staff did not recall the date of this occurrence.

After speaking with the Inspector, a RPN revised the resident's plan of care and added the behaviour of removing and hiding their personal aid with interventions. Resident Care Coordinator (RCC) acknowledged the identified behaviour on the MDS assessment on a specific date was missed in the revision of the plan of care.

There was low risk to the resident, as they did not appear to be distressed with no personal aid and staff were aware to search when the personal aids are missing.

Sources: Resident's clinical records, observations, interviews with multiple staff. [644]

Date Remedy Implemented: September 29, 2023