Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 25, 2019	2019_603194_0016	002206-18, 002256-18, 002827-18, 004003-18, 004701-18, 009024-18, 009423-18, 024749-18, 028098-18, 009907-19	Complaint

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 Wynfield Long Term Care Residence
451 Woodmount Drive OSHAWA ON L1G 8E3

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

CHANTAL LAFRENIERE (194), SARAH GILLIS (623)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 8, 9, 10, 11, 12, 15, 16, 17 and 18, 2019

The inspection included the following complaints:
Log #002206-18, related to staffing and provision of resident care.
Log #002256-18, related medication and odour.
Log #002827-18, related to falls and resident care.
Log #004003-18, related to staffing and resident care.
Log #004701-18, related to medication and doors.
Log #009024-18, related to fall and resident care.
Log #009423-18, related to allegations of staff to resident abuse.
Log #024749-18, related to trust accounts, housekeeping and fall.
Log #028098-18, related to staffing and resident care.
Log #009907-19, related to end of life care.

Non compliance for Log #009423-18, under LTCHA, 2007, s. 24(1) will be identified in Inspection #2019_591623_0010.

During the course of the inspection, the inspector(s) spoke with Residents, Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Nurse Manager (NM), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Care Provider (PCP), Registered Physical Therapist (RPT), Housekeeping staff and Consultant Resident Care and Services- Nursing.

Reviewed identified residents clinical health records, relevant policies related to abuse, falls and complaints, licensee's complaint log, back up staffing plan and trust account records of identified resident. Observed staff to resident provision of care, dining services and resident rooms.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Dining Observation
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Trust Accounts

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

- **2 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the SDM of resident #014 was provided the opportunity to participate fully in the development and implementation of the plan of care.

Related to Log #009907-19:

A complaint was received by the Director on an identified date from resident #014's SDM, related to provision of palliative care. Inspector #194 reviewed the clinical health record of resident #014, interviewed RPN #123, NM #132 and NM #133.

The clinical health records for resident #014, indicated that the resident was in the end stage of a disease. Resident #014 is described in the clinical health record as requiring total care for all ADL's.

Review of the progress notes for resident #014 indicated a decrease intake and change in condition for an identified period. NM #132 was asked by RPN #123 on an identified date, to assess resident #014 and the resident was transferred to the hospital for further assessment. RPN #123 contacted resident #014's SDM and left a message, related to the transfer to hospital.

The progress notes indicated that resident #014's SDM called the home to inquire about residents intake for the day. Resident #014's SDM was informed that the resident had been transferred to the hospital earlier in the day.

During interview with Inspector #194 related to contacting of resident #014's SDM, NM #132 indicated that, the home had been provided new contact information for SDM on an identified date. NM #132 indicated to Inspector #194 during interview, of having a discussion with resident #014's SDM after the resident's hospitalization, to determine why they had not been called when resident was transferred to the hospital. NM #132 and the SDM reviewed the clinical health records and noted that the updated contact information had not been updated in the computer system.

The licensee failed to provide resident #014's SDM the opportunity to participate fully in the development and implementation of the plan of care, when the resident was transferred to hospital. [s. 6. (5)]

2. The licensee failed to ensure that when resident #003 was reassessed and the plan of care reviewed and revised when the care set out in the plan related to the use of a mobility aid was not effective.

Related to Log #002206-18 and Log #009024-18:

A complaint was received by the Director on an identified date from resident #003's SDM, related to a fall and management of the resident's financial account.

A complaint was received by the Director on an identified date from resident #003's family, related to a staff assisted transfer.

During inspection of the two complaints received involving resident #003 , Inspector #194 reviewed the clinical health records and interviewed PSW and Registered staff. The progress notes for resident #003 during a specified time, identified the resident to be able to direct their own care but numerous incidents related to the use of a mobility aid were identified.

Resident #003 had signed an updated Agreement on an identified date. Resident #003 was noted to have difficulties with use of the mobility aid in specific areas.

Review of the plan of care for resident #003 on an identified date, related to use of the mobility aid indicated several interventions.

Review of the plan of care for Resident #003 several months later, related to use of the

mobility aid indicated additional interventions to the plan of care.

Review of the progress notes for resident #003 over a specific period of time, related to incidents with the mobility aid indicated many incidents where the resident was injured, the environment was damaged and other residents were at risk of harm.

During separate interview with Inspector #194, RN #117, RPN #104, PSW #110 and PSW #108, indicated concerns with resident #003's use of the mobility aid.

An assessment was completed for resident #003 on an identified date. A agreement with resident #003 was initiated on an identified date. There was no evidence of any further assessment being completed after numerous incident with the mobility aid were documented.

Management was informed of concerns by nursing team, related to the resident #003's use of the mobility aid.

An Occupational Therapy assessment was completed for resident #003 on an identified date and indicated that the resident's privileges related to the mobility aid should be revoked.

The licensee failed to ensure that when resident #003 was reassessed, that and the plan of care was reviewed and revised when the care set out in the plan related to the mobility aid were not effective. Review of resident #003 clinical health record indicated numerous incidents related to the use of the mobility aid for a specific period, putting the resident and others at risk in the home. Resident #003 was assessed by nursing and OT but the written plan of care related to mobility aid for resident #003 was not changed until after numerous incidents had occurred. [s. 6. (11) (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 ensuring that SDM are provided the opportunity to participate fully in the development of the plan of care and ensuring that residents are reassessed and the plan of care reviewed and revised when the care set out in the plan has not been effective., 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 that staff used safe transferring and position techniques when assisting resident #003 on an identified date.

Related to Log #009024-18:

A complaint was received by the Director from resident #003's SDM related to a staff assisted transfer. Inspector #194 identified that staff did not use safe transferring techniques when assisting resident #003.

Review of resident #003's plan of care in effect on an identified date, related to transfer was completed by Inspector #194. The plan of care identified that resident #003 was total care with two staff using specific equipment for all transfers. Resident #003 could not use a specific transfer aid, must use an identified transfer aid.

Review of the home's investigation was completed by Inspector #194 and identified that PSW #108 and #110 transferred the resident on an identified date. An identified aid was used but not properly applied. When the resident was transferred the identified aid failed and the resident had to be lowered to the floor. PSW #108 and #110 then used a specific aid to assist resident, with no injury being sustained.

During separate interview with Inspector #194, PSW #108 and #110 confirmed that the identified aid had not been applied properly and that the specific aid had been used to assist resident #003 with transfers on the identified date.

The licensee failed to ensure that PSW #108 and #110 used safe transferring techniques when assisting resident #003 when the identified aid was not applied properly, PSW #108 and #110 continued to use unsafe transferring technique when the specific aid was used, which was contraindicated the plan of care, placing resident #003 at risk for injury. [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 ensuring that the staff will use safe transferring techniques when assist residents, to be implemented voluntarily.

Issued on this 25th day of July, 2019

[redacted]

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

Original report signed by the inspector.