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
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Original Public Report

Report Issue Date: March 10, 2023	
Inspection Number: 2023-1370-0002	
Inspection Type: Critical Incident System Complaint	
Licensee: Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc.	
Long Term Care Home and City: Chartwell Wynfield Long Term Care Residence, Oshawa	
Lead Inspector Reethamol Sebastian (741747)	**Inspector Digital Signature** Reethamol Sebastian Digitally signed by Reethamol Sebastian Date: 2023.03.30 12:07:42 -04'00'
Additional Inspector(s) Joanne Zahur (589) Eric Tang (529)	

INSPECTION SUMMARY

The inspection occurred on the following date(s):

February 2-3, 6-10, 13-16, 2023

The following intake(s) were inspected:

- One intake related to a resident fall that resulted in an injury.
- Seven intakes related to allegations of staff to resident abuse.
- Two intakes related to an allegation of resident-to-resident abuse.
- One intake related to resident to resident responsive behaviours.
- Two Intakes related to allegations of staff to resident neglect.
- One intake related to a complaint related to plan of care and medication administration.

The following intakes were completed in this inspection:

- Three intakes related to resident to resident responsive behaviours.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Resident Records

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 79/10, s. 231 (b)

The licensee has failed to ensure that a resident's written records were kept up to date.

Rationale and Summary

A Critical Incident (CI) report was submitted to the Ministry of Long-Term Care (MLTC) related to a responsive behaviour altercation between two residents. The CI indicated that a resident sustained an injury as a result.

As a result of this incident a Dementia Observation Scale tool (DOS) was initiated for the resident. A review of the DOS tool indicated there were gaps in four occasions in the written record.

The Administrator acknowledged the DOS tool was required to be completed for the duration of the assessment.

Failure to not having a resident DOS tool completed would have impacted the multidisciplinary team’s approach to providing the most appropriate care, and in ensuring the safety of other residents.

Sources: Resident's DOS tool; interview with Administrator. [589]

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 29. iv.

The licensee has failed to ensure the resident had the right to raise concern without reprisal from staff members.

Rationale and Summary

A CI report was submitted to the MLTC alleging the resident was abused by a staff.

A review of the home's internal investigative notes indicated a staff had forgotten to put back a communication device after providing care to the resident. The resident then raised the concern to the care team. The alleged staff later re-approached the resident and made an inappropriate remark. Upon completion of the investigation the identified staff received a discipline.

When interviewed, the resident could remember their interaction with the staff but unable to remember their feeling towards the interaction. The resident further asserted that they no longer had issue with the staff and enjoyed the care they provided.

The identified staff could recall the remark they made to the resident, but it was meant to be sarcastic. The Director of Care (DOC) asserted that residents were free to bring up their concerns without fearing retaliation and confirmed the identified staff should not have made that remark to the resident.

There was a moderate risk and impact to the resident as the identified interaction might affect their willingness to voice their concerns to the staff without fearing reprisal.

Sources: the resident's electronic health records, home's internal investigation files; interviews with the care staff and the DOC. [529]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (10) (c)

The licensee has failed to ensure resident was reassessed and the plan of care reviewed and revised when their fall prevention strategy was ineffective.

Rationale and Summary

A CI report was submitted to the MLTC, indicating a resident had experienced an unwitnessed fall that required hospitalization.

The resident's electronic records indicated that the use of a safety device was initiated as a fall prevention strategy. The resident had experienced a fall, where it was documented that their safety device was not sounding, and the resident was reminded not to remove the device. Additionally, a review of a health assessment record also indicated the same behaviour.

The Registered Nurse (RN) Manager stated they had seen the resident removing the safety device on several occasions and it might be the noise that triggered such behavior. Both Physiotherapist (PT) and RN Manger confirmed that the identified fall prevention intervention was ineffective for the resident.

The Administrator asserted that the nursing staff was expected to document the resident's response to an intervention in their plan of care and to explore other interventions if required.

There was a moderate risk and impact to resident as other fall prevention strategies might have been implemented to mitigate their falls risk.

Sources: Resident's electronic health records; interviews with RN Manager, PT, and the Administrator. [529]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 79/10, s. 50 (2) (b) (iii)

The licensee has failed to ensure resident was assessed by a registered dietitian when they exhibited altered skin integrity.

Rationale and Summary

A CI report was submitted to the MLTC, reflecting a family concern that a resident was neglected for treatment related to their altered skin integrity which resulted in a change of status.

The resident ’s electronic health record indicated they had altered skin integrity. The home’s policy and procedure on treatment for altered skin integrity indicated a referral to the registered dietitian was to be made notifying them to assess the resident. Further review of resident’s electronic health record indicated such referral was not completed, and therefore, the altered skin integrity was not assessed by the registered dietitian at that time.

The Wound Care Coordinator and the Consultant of Resident Care and Services asserted that the nursing staff was to complete a dietary referral.

There was a moderate risk and impact to resident as the lack of dietitian assessment might have impacted the wound healing progress.

Sources: Resident ’s electronic health records, LTCH’s wound care treatment policy and procedure, interviews with the Wound Care Coordinator and the Consultant of Resident Care and Services. [529]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with s. 50 (2) (b) (iv) of O. Reg. 79/10 under the Long-Term Care Homes Act, 2007 and s. 55 (2) (b) (iv) of O. Reg. 246/22 under FLTCHA.

The licensee failed to ensure that resident was reassessed at least weekly by a member of the registered nursing staff when they exhibited altered skin integrity.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 50 (2) (b) (iv) of O. Reg. 79/10. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 55 (2) (b) (iv) of O. Reg. 246/22 under the FLTCA.

Rationale and Summary: Non-compliance with s. 50 (2) (b) (iv) of O. Reg. 79/10 under the LTCHA

1) A CI report was submitted to the MLTC, reflecting a family concern that a resident was neglected for their treatment related to their altered skin integrity which resulted in a change of status. The resident was initially admitted to the LTC facility with altered skin integrity. The home's policy and procedure on altered skin integrity treatment indicated an assessment of the areas of altered skin integrity was to be completed and documented every week. The resident's electronic records indicated the required weekly skin and wound assessments were not completed on seven occasions.

The Wound Care Coordinator and the Consultant of Resident Care and Services confirmed that the area of altered skin integrity was to be assessed weekly.

There was moderate risk and impact to resident as the identified wound was not regularly assessed and might have prolonged the wound healing progress.

Sources: Resident's electronic health records, LTCH's wound care treatment policy and procedure, interviews with the Wound Care Coordinator, and the Consultant of Resident Care and Services. [529]

Rationale and Summary: Non-compliance with s. 55 (2) (b) (iv) of O. Reg. 246/22 under the FLTCA

2) A CI report was submitted to the MLTC, reflecting a family concern that a resident was neglected for the treatment related to their altered skin integrity which resulted in a change of status. The resident was identified to have a recurrent altered skin integrity. The resident was subsequently sent to a local medical facility for further treatment. The home's policy and procedure on altered skin integrity treatment indicated an assessment of the areas of altered skin integrity was to be completed and documented every week. The resident's electronic records indicated the required weekly skin and wound assessments were not completed on two occasions.

The Wound Care Coordinator and the Consultant of Resident Care and Services confirmed that the area of altered skin integrity was to be assessed weekly.

There was moderate risk and impact to resident as their wound further deteriorated and was required to be sent to a local medical facility for additional treatment.

Sources: Resident's electronic health records, LTCH's wound care treatment policy, and interviews with the Wound Care Coordinator, and the Consultant of Resident Care and Services. [529]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b) and Infection Prevention and Control (IPAC) Standard – section 10.1

The licensee has failed to ensure that a standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Specifically, the licensee did not ensure that the hand hygiene program included access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR) as required by section 10.1 under the IPAC Standard.

Rationale and Summary

On observation, several areas in the home including hallways, and common areas, had multiple bottles of expired ABHR hand hygiene agents for resident, staff, and visitor use. The IPAC lead confirmed that expired ABHR should not have been in use in the home as it would not be as effective for hand hygiene. The LTCH was on outbreak at the time of inspection.

There was moderate risk and impact on the effectiveness of hand hygiene and potential risk for spreading infectious agents, including COVID-19 due to the use of expired ABHR.

Sources: Observations, interview with IPAC lead. [741747]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: LTCHA, 2007 s. 24 (1). 2.

The licensee has failed to ensure that suspected verbal abuse of a resident was immediately report to the Director.

Rationale and Summary

A CI report was submitted to the MLTC, related to alleged verbal abuse of resident by a staff. Review of the resident's clinical record, the home's investigation notes and interview with a staff, confirmed that the alleged verbal abuse was not reported to the Administrator until three days later. The Administrator confirmed that the Director was not immediately notified regarding the incident of abuse.

Failing to immediately report an alleged abuse incident resulted in the allegations not being investigated and risk of harm to the resident.

Sources: CIR, Resident's electronic health records, Interviews with staff, and Administrator. [741747]

WRITTEN NOTIFICATION: Duty to Protect

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with s. 19 (1) of LTCHA, 2007, s. 19 (1)

The licensee has failed to ensure resident was protected from verbal abuse by staff.

Section 2 of the Ontario Regulation 79/10 defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident".

Rationale and Summary

A CI was submitted to the MLTC, regarding an allegation of staff to resident's verbal abuse. As per the CI, the resident informed their family member that a staff responded in a threatening and intimidating manner when they expressed being unhappy with the care provided.

The home's investigation report substantiated the resident's allegation of abuse by staff. The Administrator confirmed through investigation the alleged verbal abuse was founded and the staff was disciplined.

As a result of the alleged verbal abuse towards resident by staff, the resident was fearful for their safety which impacted their sense of well-being.

Sources: CIR, Resident's electronic health records, Investigation notes and interviews with staff, and Administrator. [741747]

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with s. 20 (1) of Long-Term Care Homes Act, 2007 and s. 25 (1) of Fixing Long-Term Care Homes Act, 2021.

The licensee has failed to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into effect, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 20 (1) LTCHA, 2007. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 25 (1) FLTCA, 2021.

Rationale and Summary: Non-compliance with s. 20 (1) under the LTCHA, 2007

1) The licensee has failed to ensure a resident was protected from verbal abuse by a staff.

A CI was submitted to the MLTC, regarding an allegation of staff to resident verbal abuse. Record review indicated that a staff member informed the Administrator, that another staff was verbally threatening and provided care in an inappropriate manner to a resident. The home's investigation report documented that the identified staff did not follow the home's policy and procedure of abuse prevention.

The Administrator confirmed that thorough investigation was completed, and the alleged verbal abuse was founded, and the staff was disciplined.

Failing to ensure the home's policy was complied with related to allegations of staff to resident abuse, could increase the risk of abuse towards residents and lead to no action being taken to respond to the allegations.

Sources: CIR, Resident's electronic health records, Home's Policy: Abuse Free Communities – Prevention, Education and Analysis, Interviews with PSWs, and Administrator. [741747]

Rationale and Summary: Non-compliance with s. 25 (1) under the FLTCA, 2021

2) The licensee has failed to protect resident from physical abuse by a staff.

A CI was submitted to the MLTC, regarding an allegation of staff to resident physical abuse. Record review indicated that a staff informed the registered staff that another staff physically abused a resident while providing care. The home's investigation report documented that the identified staff did not follow the home's policy and procedure of abuse prevention. The Administrator confirmed that an investigation was completed, and the alleged physical abuse was founded, and the staff was disciplined.

Failing to ensure the home's policy was complied with related to allegations of staff to resident abuse, could increase the risk of abuse towards residents and lead to no action being taken to respond to the allegations.

Sources: CIR, Resident's electronic health records, Home's Policy: Abuse Free Communities – Prevention, Education and Analysis, Interviews with staffs, and Administrator. [741747]