Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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
Jan 31, 2019	2018_558123_0017	002633-18	Critical Incident System

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 Waterford Long Term Care Residence
2140 Baronwood Drive OAKVILLE ON L6M 4V6

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

MELODY GRAY (123)

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): December 18, 19, 20, 24 & 31, 2018 and January 2, 3, 4 & 7, 2019.

The following critical incident (CI) inspection was included in this inspection: #002364-18/2908-000008-18 related to alleged abuse/neglect.
Non-compliance O. Reg. 79/10, s. 8 (1) (b) was identified during this inspection and is included in the inspection report for complaint inspection 2018_560632_0025 / 028816-17, 010908-18, 011225-18, 011626-18, 012224-18, 013768-18, 018160-18, 025697-18 which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with residents, family member, Personal Support Workers (PSWs), registered nursing staff and the Directors of Care (DOCs).
During the course of the inspection the inspector: reviewed residents' records; reviewed the home's records including, the incident investigation record and the fall prevention and management policy and procedure and observed residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Critical incident (CI) report #2908-000009-18 submitted to the MOHLTC on an identified date in January 2018, was reviewed. It was noted that five days earlier, resident #006 fell, sustained injury and was transferred to hospital.

The resident’s health record including the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) assessment, falls assessment, progress notes and care plan was reviewed. The Morse Fall Risk assessment dated January 2018, indicated the resident was assessed as being at a specified risk of falls. The RAI-MDS assessment triggered Resident Assessment Protocol (RAP) dated January 2018, indicated the resident was assessed as being at a specified risk of falls. The resident’s care plan dated January 2018, was reviewed and it was noted the resident was at a different risk of falls.

The resident’s health record including the documents noted above was reviewed by inspector #123 and DOC #102. DOC #102 confirmed that at the time of the fall, resident #006 was assessed as being at a specified risk of falls. However, their care plan at that time indicated they were at a different risk of falls.

The home failed to ensure that the care set out in resident #006’s plan of care was based on an assessment of the resident and the needs and preferences of that resident in relation to falls prevention and management.

This non-compliance was identified as a result of CI inspection #002633-18. [s. 6. (2)]

Issued on this 5th day of February, 2019

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

Original report signed by the inspector.