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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
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Original Public Report

Report Issue Date: November 17, 2022

Inspection Number: 2022-1392-0001

Inspection Type:
Complaint
Critical Incident System

Licensee: Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc.

Long Term Care Home and City: Chartwell Waterford Long Term Care Residence, Oakville

Lead Inspector	**Inspector Digital Signature**
Waseema Khan (741104)	Waseema Khan Digitally signed by Waseema Khan Date: 2022.11.29 11:14:18 -05'00'

Additional Inspector(s)
Emmy Hartmann (748)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 24, 2022
October 25, 2022
October 26, 2022
October 27, 2022
October 28, 2022
October 31, 2022
November 1, 2022
November 2, 2022

The following intake(s) were inspected:

- Intake: #00001115-Complainant related to Abuse and neglect.
- Intake: #00001140- [CI: 2908-000007-22] related to Physical abuse Refer to Log #010359-22 for complaint.
- Intake: #00003115- [CI: 2908-000003-21] Also refer to log 021727-20. related to neglect to resident resulting in transfer to hospital.
- Intake: #00004820 concerns regarding alleged physical abuse

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Skin and Wound Prevention and Management
Infection Prevention and Control
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (L TCHA) and O. Reg. 79/10 under the L TCHA. 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. 6 (5) of the LTCHA. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 6 (5) of FLTCA.

The licensee has failed to ensure that a resident's substitute decision-maker, was given the opportunity to participate fully in the development of the plan of care when the resident had a change in condition, and new treatment ordered.

Rationale and Summary
A resident was noted to have a medical issue which the doctor examined, and ordered treatment for. Registered staff identified that when Power of Attorney (POA) was notified of a change in condition, or treatments, that the notification was documented in the progress notes, or the prescriber's order form. Registered Staff also identified that if the documentation was not in these areas, that notification would

not have occurred.

In review of a resident's progress notes and prescriber order form, there was no POA notification related to the resident's change in condition, or related to the resident's new treatment.

Director of Care acknowledged that resident's Power of Attorney (POA) was not given the opportunity to participate fully in the development of the plan of care when they had a change in condition, and when new treatment was prescribed .

Sources: Resident progress notes, prescriber order forms; interviews with Registered Staff and DOC.

B. A resident was noted to have a dietary assessment completed by the dietitian following a weight change.

The home's policy related to weight change, identified that changes in resident weight would be discussed with the POA including any planned interventions.

There was no documentation related to the weight change in the resident's assessment and the progress notes.

DOC identified that the resident's POA was not notified of the weight change.

By not involving the resident's POA, of the resident's change in condition, and treatments, the POA was not given the opportunity to participate fully in the development of the plan of care.

Sources: Resident progress notes, assessments, the home's Weights and Heights Policy, last revised October 2018; interview with DOC.

[748]

WRITTEN NOTIFICATION: Weight Changes

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 69. 2.

The licensee failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken, and outcomes are evaluated: A change of 7.5 per cent of body weight, or more, over three months.

There was no assessment by the dietitian in Point Click Care (PCC) for a resident with a change of 7.5 per cent of body weight, or more, over 3 months.

DOC verified that an assessment of the resident should have been completed but that it was not done.

The resident may have been at increased risk for their nutritional plan of care not meeting their current nutritional needs as they were not assessed by the dietitian.

Sources: Resident weights; progress notes, assessments; interviews with RD, and DOC.

[748]

WRITTEN NOTIFICATION: Emergency plans

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 268 (4) 3.
The licensee has failed to ensure that the required hand hygiene products in the home have not expired

Rationale and Summary

While the Inspector toured the home areas, it was noted that there was a widespread issue of expired hand sanitizers inside residents' rooms. The alcohol-based hand rub (ABHR) in a residents room on contact precautions was expired. This was brought to attention of the registered Staff working in that home area. Interviews with DOC and Administrator confirmed expired hand sanitizers in the home. Registered staff verified the expired products.

The impact to residents was low at the time of the observation; however, there is a potential risk for infection transmission due to the expired hand sanitizer

Sources: Observations on home areas, Interviews with DOC and Administrator
[741104]

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