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
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Hamilton, ON, L8P 4Y7
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Original Public Report

Report Issue Date: September 5, 2023
Inspection Number: 2023-1392-0005
Inspection Type: Complaint Critical Incident
Licensee: Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
Long Term Care Home and City: Chartwell Waterford Long Term Care Residence, Oakville

Lead Inspector	**Inspector Digital Signature**
Adiilah Heenaye (740741)	Adiilah H Heenaye Sumser Digitally signed by Adiilah H Heenaye Sumser Date: 2023.09.07 09:55:31 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: August 17,2023, and August 22-24, 2023

The following intakes were inspected in this critical incident inspection:

- Intake: #00088496/ CI was related to improper/incompetent treatment of a resident.
- Intake: #00093668/ CI: 2908-000019-23 was related to falls.

The following intake was inspected in this complaint inspection:

- Intake: #00093315/ eCorrespondence: 245-2023-1893 was related to abuse and neglect.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
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 #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan related to skin integrity.

Rationale and Summary

A resident had an area of altered skin integrity. The resident's care plan indicated that the resident was required to wear a device at all times to promote healing.

The inspector observed the resident with the device not in place.

The inspector returned to the resident's room two hours later. The resident was observed with the device in place as required.

Sources: Review of the care plan of a resident's, Interview with Registered staff and other staff, Observations of the resident's room. [740741]

Date Remedy Implemented: August 24, 2023

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident's written plan of care was reviewed and revised when a resident's need changed.

Rationale and Summary

A) A resident reported an alleged incident of verbal abuse by a staff towards the resident. The home completed an internal investigation, and it was determined that the staff would no longer provide care to the resident.

The written plan of care was updated to include the new intervention seven days after it was put place when the resident's care needs changed.

Sources: A resident's clinical record; interview with the Director of Care (DOC). [740741]

B) A resident sustained a fall. The inspector observed a falls intervention for the resident, but that intervention was not included in the resident's written plan of care.

The DOC stated they were unaware that the intervention was implemented for the resident and that the written plan of care was not updated.

Sources: A resident's clinical record; Interview with the DOC and staff. [740741]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that a resident was transferred as specified in the resident's plan of care.

Rationale and Summary

The plan of care for a resident related to transfer was with two staff.

A staff transferred the resident on their own. The resident sustained an injury during the transfer.

The DOC confirmed that the plan of care was not followed for the resident.

By the home not following the resident's plan of care related to transfers, resulted in actual harm to the resident. [740741]

WRITTEN NOTIFICATION: Plan of Care - Documentation

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of care as set out in the plan of care, for a resident was documented.

Rationale and Summary

A resident made a complaint alleging that they were not receiving a specified care. According to the plan of care, the resident was to receive the care on every shift. Point of Care (POC) did not include documentation that the care was completed on several occasions.

Staff did not document the provision of care as set out in the plan of care for the resident.

Sources: Clinical records for a resident; Interview with the DOC. [740741]

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a)

The licensee has failed to ensure that when a report was made to the home about an alleged incident of staff to resident verbal abuse and neglect that an investigation was immediately started.

Rationale and Summary

A resident reported an alleged incident of verbal abuse and neglect to the home.

There was no investigation into the alleged incident of staff to resident verbal abuse and neglect.

Failure to investigate the alleged incident of staff to resident abuse, increased the risk for a resident to be harmed.

Sources: Interview with the DOC and staff; review of the complaints log and investigations package for resident #001. [740741]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to immediately report the suspicion and the information upon which it was based to the Director when they had reasonable grounds to suspect abuse and neglect of a resident by staff that resulted in a risk of harm to the resident.

Rationale and Summary

A resident reported an alleged incident of verbal abuse and neglect to the home.

The home's management confirmed that the Director was not immediately notified of the incident.

Failing to immediately notify the Director placed the resident at risk of harm.

Sources: Interviews with the DOC and Staff; Review of the Investigations package of the home. [740741]

WRITTEN NOTIFICATION: Dealing with complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.

The licensee has failed to ensure that when a written complaint was made to the home by a resident alleging verbal abuse and neglect from a staff, that the complaint was investigated immediately, and that a written response was provided to the resident within 10 business days.

Rationale and Summary

A resident sent a written complaint to the home alleging neglect and verbal abuse by a staff, including another incident of verbal abuse between staff that the resident witnessed.

The home initiated an investigation related to the concerns of the resident about their witnessed staff to staff verbal abuse.

The DOC confirmed that the home did not investigate into the alleged incident of verbal abuse by a staff to the resident, and neglect, and that a written response was not provided to the resident.

Sources: Interview with the DOC and staff; Review of the home's investigations package. [740741]