Ontario

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 le Loi de 2007 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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jun 18, 2018;	2018_542511_0005 (A3)	025282-17, 025285-17, 025286-17	Follow up

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 Willowgrove Long Term Care Residence
1217 Old Mohawk Road ANCASTER ON L9K 1P6

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

Amended by LISA VINK (168) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

Edits completed to remove personal health information.

Issued on this 19 day of June 2018 (A3)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Amended by LISA VINK (168) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): February 26, 27, 28, March 1, 5, 7, 8, 9, 13, 14,15, 2018.

The following intakes were completed during this follow-up inspection:

#025282-17 related to Resident Abuse,

#025285-17 related to Nutrition and Hydration program,

#025286-17 related to Medication Management.

PLEASE NOTE: A written Notification and Compliance Order related to LTCH, 2007, s.19 (1), identified in a concurrent CIS inspection #2018_542511_0006 (024512-17, 025757-17, 026071-17, 001707-18, 003111-18) was issued in this report.

During the course of the inspection, the inspector(s) spoke with Administrator, Director(s) of Care, Registered staff inclusive of Registered Nurse(s) (RNs) and Registered Practical Nurse(s) (RPNs), Nurse Practitioner, Clinical Nurse Consultant, Personal Support Workers (PSWs), MDS-RAI Coordinator, residents and applicable family members.

During the course of the inspection, the Inspector toured the home, observed

the provision of care, observed medication pass, meal service, snack passes, reviewed clinical records,

policies and procedures, the home's complaints process, investigative notes and conducted interviews.

The following Inspection Protocols were used during this inspection:

Medication

Nutrition and Hydration

Prevention of Abuse, Neglect and Retaliation

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

- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 131. (1)	CO #004	2017_689586_0003	511
O.Reg 79/10 s. 26. (4)	CO #003	2017_689586_0003	632

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	Legendé 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

(A3)
The licensee failed to ensure resident #008 was protected from abuse by resident #007.

A) A Critical Incident report, was received by the Ministry of Health and Long Term Care in 2017. The report described a mandatory report of abuse by resident #007 to resident #008.

A review of the clinical record of resident #008 and #007 documented they both had an impairment. Interview with RN #204 and RN #209 stated resident #008 was unable to provide consent to an inappropriate behaviour from resident #007.

Resident #008 was not protected from abuse when they had not consented to an inappropriate behaviour, directed towards them, by resident #007.

B) During an interview with PSW #208 they stated that after they observed resident #007 with resident #008 they needed to obtain assistance from the RN in charge. PSW #208 stated they left resident #007 alone with resident #008 to locate the nurse in charge. RN #209 was located outside of the home unit and returned with the PSW to resident #008, a few moments later.

Resident #008 was not protected from abuse when they were left alone with resident #007 after staff were aware of the abuse in progress.

C) A review of the clinical record for an identified resident identified multiple reports from external care providers that had identified inappropriate behaviours prior to admission and included recommended strategies for these behaviours. An interview with an external care provider stated they had received a referral from the Local Health Integration Network (LHIN) placement coordinator to provide an assessment to assist with the resident's transition to long term care. The external care provider stated they completed assessments and a written plan of care to address the identified behaviours. This assessment was located in the resident's clinical record.

A review of resident #007's admission plan of care, as provided and verified by registered staff #203, had not included all strategies to mitigate the resident's inappropriate behaviours as provided by the external care providers.

Resident #008 was not protected from abuse when, according to the admission documents, the licensee had knowledge of resident #007’s identified behaviours, that posed a potential risk to co-residents, and had not included the recommended strategies that could mitigate these risks to co-residents.

D) Resident #007’s post admission progress notes identified the resident had continued, on multiple occasions, to demonstrate inappropriate behaviours.

Interview with registered staff #204 stated they had knowledge of resident #007's previous behaviour towards resident #008 and that an intervention was put in place for the safety of resident #008. A review of resident #008's plan of care identified the safety intervention was to be implemented over three consecutive months, which included the time frame of the incident of abuse. Interview with PSW #208 stated the safety intervention was not implemented at the time of the abuse as per the plan of care.

Interview with the DOC stated the safety intervention should have been implemented as per resident #008's most recent plan of care.

Resident #008’s was not protected from abuse when their safety was not ensured, as directed in their plan of care.

Interview with RN #210 stated, after a review of the clinical record, the home had knowledge that resident #007 had exhibited several incidents of inappropriate behaviours prior to the incident of abuse to resident #008. RN #210 stated resident #007 responded to redirection by the staff. This immediate intervention of redirection was limited to direct observation of the resident’s behaviour by the staff. However, the resident had continued to exhibit inappropriate behaviours, and if not directly observed and redirected by staff, due to their disease process, would continue the inappropriate behaviour, posing a risk to resident #008 and co-residents.

The licensee failed to ensure resident #008 was protected from abuse when:
A) Resident #008 had not consented to a behaviour, directed towards them, by resident #007.
B) Resident #008 continued to be left alone with resident #007.
C) Resident #007’s admission plan of care, had not included interventions that had been identified as effective by external care providers.
D) Resident #008’s safety intervention was not implemented at the time of the abuse, as specified in their plan of care.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A3)The following order(s) have been amended:CO# 001

Issued on this 19 day of June 2018 (A3)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Long-Term Care Homes Division
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Inspection de soins de longue durée

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by LISA VINK (168) - (A3)

Inspection No. / No de l'inspection : 2018_542511_0005 (A3)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 025282-17, 025285-17, 025286-17 (A3)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Jun 18, 2018;(A3)

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

LTC Home / Foyer de SLD :
Chartwell Willowgrove Long Term Care Residence
1217 Old Mohawk Road, ANCASTER, ON, L9K-1P6

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Natasha Murray

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To Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2017_689586_0003, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

(A3)
The licensee must be compliant with LTCHA, 2007 s. 19 (1).
Specifically the licensee shall ensure:
a) Resident #008 and all other residents that can not provide consent to an activity as a result of a behaviour be protected from abuse by anyone.
b) Resident #008 and all other residents, that are observed by staff, during a specific behaviour are separated and not left alone or unsupervised.
c) The home develops a documented process to ensure the review of the assessment, reassessments, strategies and other information provided by external care providers and placement coordinator for residents demonstrating inappropriate behaviours.
d) A documented auditing process, for resident #008 and all other residents, that require the use of a physical device to ensure their safety from co-residents in the home. This includes but is not limited to all interventions as per the residents' plan of care.

Grounds / Motifs :

(A3)
1. The licensee has failed to comply with compliance order #001 from inspection # 2017_689586_003 (A3), served on October 25, 2017, with a compliance date of December 20, 2017.

The licensee was ordered to prepare, submit and implement a plan to ensure that every resident, including residents #021, #022, #025 and #028, was protected from verbal and physical abuse by anyone, including staff, and to ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure that all residents, which included resident #008, were protected from abuse.

A) A Critical Incident report, was received by the Ministry of Health and Long Term Care in 2017. The report described a mandatory report of abuse by resident #007 to resident #008.

A review of the clinical record of resident #008 and #007 documented they both had an impairment. Interview with RN #204 and RN #209 stated resident #008 was unable to provide consent to an inappropriate behaviour from resident #007.

Resident #008 was not protected from abuse when they had not consented to an inappropriate behaviour, directed towards them, by resident #007.

B) During an interview with PSW #208 they stated that after they observed resident #007 with resident #008 they needed to obtain assistance from the RN in charge. PSW #208 stated they left resident #007 alone with resident #008 to locate the nurse in charge. RN #209 was located outside of the home unit and returned with the PSW to resident #008, a few moments later.

Resident #008 was not protected from abuse when they were left alone with resident #007 after staff were aware of the abuse in progress.

C) A review of the clinical record for an identified resident identified multiple reports from external care providers that had identified inappropriate behaviours prior to admission and included recommended strategies for these behaviours. An interview

with an external care provider stated they had received a referral from the Local Health Integration Network (LHIN) placement coordinator to provide an assessment to assist with the resident's transition to long term care. The external care provider stated they completed assessments and a written plan of care to address the identified behaviours. This assessment was located in the resident's clinical record.

A review of resident #007's admission plan of care, as provided and verified by registered staff #203, had not included all strategies to mitigate the resident's inappropriate behaviours as provided by the external care providers.

Resident #008 was not protected from abuse when, according to the admission documents, the licensee had knowledge of resident #007's identified behaviours, that posed a potential risk to co-residents, and had not included the recommended strategies that could mitigate these risks to co-residents.

D) Resident #007's post admission progress notes identified the resident had continued, on multiple occasions, to demonstrate inappropriate behaviours.

Interview with registered staff #204 stated they had knowledge of resident #007's previous behaviour towards resident #008 and that an intervention was put in place for the safety of resident #008. A review of resident #008's plan of care identified the safety intervention was to be implemented over three consecutive months, which included the time frame of the incident of abuse. Interview with PSW #208 stated the safety intervention was not implemented at the time of the abuse as per the plan of care.

Interview with the DOC stated the safety intervention should have been implemented as per resident #008's most recent plan of care.

Resident #008's was not protected from abuse when their safety was not ensured, as directed in their plan of care.

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observed and redirected by staff, due to their disease process, would continue the inappropriate behaviour, posing a risk to resident #008 and co-residents.

The licensee failed to ensure resident #008 was protected from abuse when:
A) Resident #008 had not consented to a behaviour, directed towards them, by resident #007.
B) Resident #008 continued to be left alone with resident #007.
C) Resident #007's admission plan of care, had not included interventions that had been identified as effective by external care providers.
D) Resident #008's safety intervention was not implemented at the time of the abuse, as specified in their plan of care.

The severity of this issue was determined to be a level 3 as there was actual harm and risk to the resident. The scope of the issue was a level 1 as it related to one of three residents reviewed. The home had a level of 4 history as they had ongoing non-compliance with this section of the LTCHA that included:
voluntary plan of correction (VPC) issued on November 1, 2016 (2016_215123_0014)
Compliance Order (CO) #001 issued on October 25, 2017 with a compliance due date of December 20, 2017(2017_689586_0003). (511)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

May 20, 2018(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 19 day of June 2018 (A3)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by LISA VINK - (A3)

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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Service Area Office / Bureau régional de services : Hamilton