Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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

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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
Dec 19, 2019	2019_560632_0028	018898-19	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 Willowgrove Long Term Care Residence
1217 Old Mohawk Road ANCASTER ON L9K 1P6

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

YULIYA FEDOTOVA (632)

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 9, 10, 11, 12, 13, 2019.

The following Critical Incident System (CIS) inspection was completed:
log #018898-19 - related to prevention of abuse and neglect, responsive behaviors.

Complaint inspection #2019_560632_0027 was conducted concurrently with this inspection:
log #020983-19 - related to staffing.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care #1, Director of Care #2, Nurse Practitioner, Recreationist, Program Support Service Manager, Housekeeper, Behavioral Support Ontario (BSO) personal support worker (PSW), PSWs, registered nurses (RNs), residents and their families.

During the course of the inspection, the inspector(s) observed the provision of care and services, reviewed documentation, including, clinical health records, policies and procedures.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following were developed to meet the needs of resident with responsive behaviors: 1. Written approaches to care, including assessment and reassessment and identification of behavioral triggers that might result in responsive behaviors, whether cognitive, physical, emotional, social, environmental or other.

A CIS report was submitted to the Ministry of Long-Term Care (MOLTC) indicating altercation between resident #002's and residents' #001, #003, #004, and #005.

According to resident #002's written plan of care, they displayed some identified behaviors. A review of the CIS report indicated that on identified date in September 2019, there was an altercation between resident #002 and residents' #001, #003's, #004 and #005. The residents were separated by staff and assessed for injuries. There were no injuries sustained by residents' #001, #003, #004 and #005.

Review resident #002's progress note indicated that on identified dates in August 2019 the resident exhibited an identified behavior. As a result, the resident was sent to the hospital for an assessment. Review of clinical documentation and an interview with BSO PSW #109 indicated that no assessment and/or reassessment and identification of the specified triggers that might result in responsive behaviors were completed, which was confirmed by the DOC #101.

Review of the home's Responsive Behavior Policy stated that through individual assessments and analysis of identified incidents, staff should be aware and sensitive to resident's behavioral patterns. An interdisciplinary analysis of each incident should be carried out to serve the purpose of prevention in the future.

The home failed to ensure that written approaches to care, including assessment and reassessment and identification of behavioral triggers that might result in responsive behaviors were developed for resident #002. [s. 53. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that the following is developed to meet the needs of resident with responsive behaviors 1. Written approaches to care, including assessment and reassessment and identification of behavioral triggers that may result in responsive behaviors, whether cognitive, physical, emotional, social, environmental or other, to be implemented voluntarily.

Issued on this 20th day of December, 2019

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

Original report signed by the inspector.