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

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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
Jul 29, 2021	2021_857129_0004	001834-20, 016199-20, 001202-21, 007581-21, 008115-21	Critical Incident System

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
7070 Derrycrest Drive Mississauga ON L5W 0G5

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

PHYLLIS HILTZ-BONTJE (129), LEAH CURLE (585)

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): May 12, 13, 14, 17,18,19,20,25, 26, 27, 28, 31, June 1, 2, 3, 4, 7, 8, 9, 10, 11, 14, 15, 16, 17, 18, 21, 22, 2021.

The following intakes were inspected
001834-20 and 008115-21 related to resident abuse
001202-12 and 016199-20 related to falls
007581-21 related to a missing resident

PLEASE NOTE:
A Voluntary Plan of Correction related to (LTCHA, 2007, c. 8, s. 33(3) was identified in this inspection and has been issued in Complaint Inspection Report #2021_857129_0004, dated May 12, 2021, which was conducted concurrently with this inspection.
A Voluntary Plan of Correction related to O. Reg. 79/10, s. 8(1)(b) was identified in this inspection and has been issued in Complaint Inspection Report #2021_857129_0004, dated May 12, 2021, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with residents, resident family members, Personal Support Workers, staff completing COVID-19 screening, Registered Practical Nurses, Registered Nurses, RAI Coordinator and RAI Back-up Coordinator, Physiotherapist, Maintenance Supervisor, DOC #101, DOC #102 and the Administrator.

During the inspection, Inspectors observed residents and resident's environments, reviewed clinical records, reviewed Critical Incident Reports, reviewed infection prevention and control documents and records, reviewed temperature monitoring records, reviewed emergency plans, reviewed investigation notes made by the home and reviewed Licensee's policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **6 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The licensee failed to ensure the home was a safe and secure environment when a resident demonstrated an identified responsive behaviour, when the requirement for newly admitted residents to isolate for a 14-day period was not maintained and when the requirement for active COVID-19 screening was not maintained.

a) Staff did not ensure the resident's environment was safe when the resident demonstrated an identified responsive behaviour.

Five days after the resident was admitted to the home they demonstrated the identified responsive behaviour which placed them at risk for injury.

The following inaction by staff increased the risk that the resident would be exposed to risks in the environment when they demonstrated the identified responsive behaviour.

i. Staff did not complete an assessment or develop a care plan that was based the information available on the resident's admission to the home. Information available to staff indicated the resident had a moderate cognitive impairment and on more than one occasion they had demonstrated a specific responsive behaviour that put their safety at risk.
The failure of staff to assess and develop a care plan related to the identified responsive behaviour that was demonstrated prior to their admission to the home, resulted in the resident being admitted to a non-secure home area and plans to monitor the resident were not put in place to ensure the resident's safety.

ii. The clinical record indicated the resident may have demonstrating the above identified responsive behaviour to a Registered Nurse (RN) on the evening of their admission and to a Personal Support Worker (PSW) five days after they were admitted to the home. The home is in a location that is adjacent to a wooded area and there is immediate and easy access to three major roadways and city streets.
The failure of staff to consider the risks present in the environment surrounding the home and take action when there was evidence that the resident demonstrated the identified behaviour, resulted in the resident being exposed to those risks, when they demonstrated the responsive behaviour and an incident occurred.

iii. Staff did not consider the resident's unique characteristics in the development of plans to keep the resident safe. A RN who observed the resident in the hallway documented that they did not immediately recognize them as a resident due to four identified characteristics that set them apart from other resident's living in the home. A staff person who was responsible for completing COVID-19 screening at the entrance to the home indicated they had activated the automatic door opener at the front door for the resident because they believed the resident to be a visitor to the home.
The failure of staff to put in place plans that identified this resident as a resident who

demonstrated a specific responsive, resulted in this resident continuing to be at risk of being misidentified by staff who did not know the resident and other visitors to the home, which increased the chance that the resident would be placed at risk when they demonstrated the identified responsive behaviour..

iv. Staff did not practice the Sign In/Out Protocol that was identified in the Licensee's Emergency Response Plan for Code Yellow. The protocol directed that “all residents, visitors and staff were always required to sign into/out of the building in the Sign In/Out Register.” The plan indicate the Registry was to be completed for safety reasons and in times of emergencies the Registry was the first point of reference for the number of people in the home. The Administrator acknowledged that the Registry had not been maintained because people were being screened for COVID-19.
The failure of staff to maintain the sign in/out registered resulted in the resident demonstrating the identified behaviour and an incident occurred that jeopardized their safety.

The failure of staff to consider the resident's safety and security needs resulted in the resident demonstrating a responsive behaviour which resulted in an incident that jeopardized the resident’s safety.

Sources: observations of the resident, 24-hour care plan, admission information, progress notes, observations of the area around the home, Emergency Response Plan-Code Yellow, and interviews with staff #141 and the Administrator.

b) Staff did not ensure the home was safe environment for resident, staff, and visitors to the home when they did not ensure the resident maintained a 14-day period of isolation when they were admitted to the home.

COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care Home Act, 2007, issued and effective April 7, 2021 directed that when a home is not in outbreak:
All admissions and transfers into the LTCH must have a laboratory (lab)-based PCR COVID-19 test in accordance with the COVID-19: Provincial Testing Requirements Update. A negative result does not rule out the potential for incubating illness and all new residents who have not been previously cleared of COVID-19 must remain in isolation under Droplet and Contact Precautions for a 14-day period following arrival. The receiving LTCH must have a plan for the individual being admitted/transferred to complete 14-days of self-isolation under Droplet and Contact Precautions. Individuals

must be placed in a single room on admission to complete their 14-day self-isolation.

The resident was admitted in 2021 and was to remain in their room in isolation for a 14-day period. Information available at the time of admission indicated the resident had a moderate cognitive impairment and walked independently without the use of an aid.

A review of the clinical record indicated that during the late evening on an identified date, registered staff documented that the resident was pleasantly confused and they started to come out of their room and needed to be taken back to their room. An hour later on the same day, registered staff documented the resident was out of their room and walking in the hallway. In a written statement made by a Registered Practical Nurse (RPN), they indicated that they saw the resident on an identified date just before dinner, the resident appeared confused and was redirected back to their room. Two hours later on the same day, registered staff documented that a PSW staff reported the resident could not be found in their room.

A review of the resident's care plan indicated that a plan of care had not been initiated related the requirement for this resident to isolate or how staff were to maintain the resident in isolation when the resident demonstrated a lack of understanding that they were to remain in their room.

The failure of staff to maintain the required 14-day period of isolation for the resident, placed other residents, staff, and visitors to the home at risk for contracting COVID-19.

Sources: clinical notes made by registered staff, written statement by non-registered staff, interview with DOC #102 and Directive #3 (effective April 7, 2021)

c) Staff did not ensure the requirement to complete active COIVID-19 symptom screening twice daily, for all staff, visitors, and anyone else, was complied with.

Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, issued and effective on April 7, 2021, directed:
“LTCHs must immediately implement daily active screening of all staff, visitors and anyone else entering the LTCH. Active screening must include twice daily (at the beginning and end of the day or shift) symptom screening.”

The home had developed a COVID-19 screening tool and implemented a process where screening stations were set up at the front entrance of the home. Access to the home

was limited to the front entrance, staff and others passed by screening stations upon entering and exiting the home, where staff were assigned to ensure screening was completed.

Staff #141 indicated that during the evening on an identified date, a person they thought was a visitor to the home entered the lobby from inside the home, walked to the front door, looked at staff #141 who was sitting at a screening table and they activated the automatic door opener and the person walked out of the home. Staff #141 who was assigned to complete screening, indicated this was their usual practice. During an interview, staff #141, acknowledged that they were not trained to screen people leaving the home and they had not been doing this.

When it was brought to the attention of the Administrator that active screening of people leaving the home had not been occurring, they acknowledged this was the case.

Staff did not ensure the safety of residents, staff, and visitors when they did not ensure that active screening was occurring twice a day as was required.

Staff's failure to ensure that required infection prevention and control practices, specifically, twice a day active COVID-19 screening, were being performed, increased the risk to persons in the home for contracting this infection.

Sources: COVID-19 screening tool, interviews with staff #141, DOC #102, the Administrator and Directive #3 (effective April 7, 2021) [s. 5.]

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 the home is a safe and secure environment for the residents, to be implemented voluntarily.

WN #2: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

The licensee failed to ensure a resident's plan of care related to falls was reviewed and revised when the care set out in the care plan had not been effective and the resident continued to fall.

The resident's care plan included a care focus related to falls that was initiated two and a half years prior to this inspection. The goal of care was identified as; "care interventions will be maintained to sustain status" and was current at the time of this inspection.

Care interventions were not effective when the resident began to fall and fell eight times over a five-month period. On one occasion a fall resulted in the resident sustaining an injury which required treatment in hospital.

A RPN reviewed the resident's care plan related to falls and acknowledged that the goal of care should not be to maintain status because the resident had fallen multiple times.

On June 7, 2021, DOC #101 acknowledged the goal of care was not currently appropriated based on the resident's frequent falls and the care plan had not been reviewed when the care had not been effective in relation to falls management.

Failure of staff to review and revise the resident's care plan when the care being provided was not effective, resulted in the resident continuing to experience falls and increased the risk that the resident would sustain injuries from falling.

Sources: the resident's care plan, electronic clinical notes and interviews with RPN #132 and DOC #101. [s. 6. (10) (c)]

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 the resident is reassessed and the plan of care reviewed and revised then the care set out in the plan has not been effective, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 :

The licensee failed to ensure that a resident was protected from emotional abuse by a PSW.

Section 2 (1) of the Ontario Regulation 79/10 defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

On an identified date, a PSW was with the resident in their room, providing care for an extended period. A RN approached the PSW to inquire about what they were doing and the PSW said the resident was slow.

The following day, it was noted that the resident told staff they did not get any sleep all night and they were sorry they were such a problem and burden on everyone.

At the time of this inspection the resident confirmed the incident occurred and indicated it made them fell bad about themselves. In response to questions about the actions taken by the home following the incident, the resident reported the PSW apologized. The resident indicated they did not feel positive about the actions taken by the home, felt they did not have any control over the situation, they continued to feel hurt by what the PSW said about them and they did not feel comfortable with the PSW.

The PSW stated they had no intention to cause harm to the resident; however, confirmed they made the remarks and acknowledged them as inappropriate.

The Administrator confirmed the resident was not protected from emotional abuse by the PSW.

The incident resulted in harm to the resident as they experienced low self-worth and uncertainty in believing it would not happen again.

Sources: Critical Incident (CI) report #2921-000013-21 and investigative notes, interview with the resident, PSW #107 and the Administrator. [s. 19. (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 residents are protected from abuse by anyone and that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

The licensee failed to ensure that an alleged incident of abuse that resulted in a resident experiencing pain and a skin injury was immediately investigated.

O. Reg. 79/10 s. 2(1) states: physical abuse means the use of physical force by anyone other than a resident that causes physical injury or pain.

The resident experienced pain and sustained a wound on an identified date, when a PSW provided their care. Clinical documentation, assessments, written statements, and interviews indicated several staff had knowledge of the incident and the injury but did not immediately investigate the incident.

A written statement by the PSW, indicated that while providing care to the resident, the resident began to scream, and the resident told them they were being too rough and hurting them. The PSW left the resident and asked a second PSW to finish providing care to the resident. The second PSW reported to the first PSW that the resident said they had been very rough with them and the resident had an open sore. The first PSW indicated they reported the incident to the RN the following day, who told them to report it to DOC #139 and that the RN had applied a dressing to the resident's sore.

A written statement by the second PSW confirmed they were asked to complete the resident's care because the resident had told the first PSW that they were being too rough and hurting them. They indicated that the following day they went to provide care to the resident and the resident was still upset about the incident that had occurred the day before.

At the time of this inspection, the second PSW said the resident told them that the first PSW was very rough and they did not want that PSW to provide care to them.The second PSW said they observed the resident to have a wound that was bleeding when they were asked to complete the resident’s care. They said they reported this to the RPN who worked that day.

The clinical record indicate that RN #129 had knowledge of the injury the resident sustained when they completed a skin assessment for the resident which was dated the day of the incident. The reason for the assessment was identified as "new skin alteration" and the RN documented that the resident had a wound and that the resident's plan of care was updated the following day.

The clinical record indicated that DOC #139 had knowledge of the injury sustained by the resident when they completed a pain assessment for the resident, on the day of the incident. The assessment indicated the reason for completing the assessment was "pain during care had been reported", that the resident had pain at a level four and the resident's care plan had been updated.

A "Summary of Investigation" document completed by the Administrator, identified that education on reporting allegations of abuse would be reviewed with registered staff and PSWs.

During an interview with the Administrator they acknowledged that the two PSWs, and

based on documentation made in the clinical record, DOC #139 and RN #129 had knowledge of the incident and the injury to the resident. They acknowledged an investigation had not been initiated until after they had received information from a family member, five days after the incident.

Failure of staff to immediately investigate an incident when the resident identified a staff person had been rough with them which resulted in the resident sustaining an injury and experienced pain, resulted in a risk that the resident's emotional and safety concerns would not be addressed.

Sources: written statements by PSW #140 and PSW #136, Skin and Pain Assessments, Summary of Investigation document as well as interviews with PSW #136 and the Administrator. [s. 23. (1) (a)]

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 every alleged, suspected or witnessed incident of abuse of a resident, that the licensee knows of or that is reported to the licensee is immediately investigated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee failed to ensure that the Director was immediately notified when staff had grounds to believe a resident may have been abused by a PSW.

On the day of the incident the resident reported to a PSW that another PSW who provided care to them had been very rough with them and documentation in their plan of care confirmed the they experienced pain and a wound as a result of the PSW's actions.

In a written statement completed by the PSW, they confirmed that while they were providing care to the resident, the resident told them they were too rough, were hurting them and yelled at them to stop what they were doing.

A skin assessment dated on the day of the incident and completed by a RN, indicated the reason for the assessment was "new skin alteration" and confirmed that the resident had sustained a wound that required treatment.

A pain assessment dated on the day of the incident and completed by DOC #139, identified the reason for the assessment was "pain during care had been reported" and confirmed that the resident experienced pain at a level four and the care plan had been updated.

During an interview with a PSW, they confirmed that on the day of the incident, the resident told them that the other PSW was very rough with them and they did not want that PSW to provide care to them anymore. They also acknowledged that they observed the resident to have a wound that was bleeding, which they reported to the RPN that was working that day.

The Administrator confirmed the Director was not notified of the suspected incident of abuse until four days after the incident had occurred and after the family member of the resident had contacted them to inquire how to report an incident of resident abuse.

Sources: written statements of PSW #140 and PSW #136, Critical Incident Report, Skin and Pain assessments and interviews with PSW #136 and the Administrator. [s. 24. (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 a person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm to the resident occurred is immediately reported to the Director, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (4) The licensee shall ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act. O. Reg. 79/10, s. 24 (4).

s. 24. (9) The licensee shall ensure that the resident is reassessed and the care plan is reviewed and revised when,
(a) the resident's care needs change; O. Reg. 79/10, s. 24 (9).
(b) the care set out in the plan is no longer necessary; or O. Reg. 79/10, s. 24 (9).
(c) the care set out in the plan has not been effective. O. Reg. 79/10, s. 24 (9).

Findings/Faits saillants :

The licensee failed to ensure that care set out in the 24-hour admission care plan was based on information provided by the placement co-ordinator and an assessment of the risk that a resident would demonstrate an identified responsive behaviour.

Five days following the resident's admission to the home they demonstrated the responsive behaviour identified in the admission documentation.

A review of the clinical record confirmed that staff did not complete an assessment or develop a care plan based on information provided by the placement co-ordinator in a Personal Health Profile and a Physician's assessment. These two documents indicated

the resident had a moderate cognitive impairment and they frequently demonstrated the identified responsive behaviour prior to their admission to the home.

A review of the clinical record confirmed that a RN did not complete an assessment or develop a care plan when they documented they had observed the resident to demonstrate the responsive behaviour on the evening of their admission to the home. The RN documented in the clinical record that staff were to be aware of the resident's whereabouts at all times.

Following a review of clinical documentation, DOC #102 confirmed that the resident's care plan had not been based on information provided by the placement co-ordinator or on an assessment of risk related to the observations the RN made on the evening of admission.

Staffs failure to assess the resident and develop a 24-hour care plan related to safety and the risk the resident would demonstrate the identified responsive behaviour, resulted in the resident being place at risk for injury.

Sources: the resident's care plan, interRAI Personal Health Profile - Assessment, a Physician Assessment, clinical notes and interview with DOC #102. [s. 24. (4)] (129)

2. The licensee failed to ensure that a resident's 24-hour care plan was revised when their care needs changed, and they demonstrated an identified responsive behaviour that resulted in them being place at risk for injury.

The clinical record and the home's investigative notes indicated that the resident demonstrated the identified responsive behaviour that placed them at risk five days after they were admitted to the home.

A review of the 24-hour care plan indicated that a care plan focus, care goal and interventions related to the identified responsive behaviour were not put in place for two days after the incident that placed the resident at risk.

DOC #102 acknowledged that the 24-hour care plan related to the management of the responsive behaviour had not been put in place until two days following the incident.

Staff continued to expose the resident to a risk of injury over a two-day period when they

failed to ensure the care plan was revised to include safety measure and prevention strategies to minimize a recurrence the of the incident that placed the resident at risk.

Sources: Clinical notes, the resident's care plan and an interview with DOC #102. [s. 24. (9) (a)]

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 the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment , reassessment and information provided by the placement co-ordinator and that the resident is reassessed and the care plan is reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

The licensee failed to ensure that staff complied with the licensee's policy to promote zero tolerance of abuse when staff who had reasonable grounds to suspect that a resident may have been abused by a PSW, did not immediately report the incident to the Director and a thorough investigation into the incident was not conducted.

Licensee's written policy "Abuse Allegations and Follow-Up" identified as LTC-CA-WQ-100-05-02, revised in July 2016, directed:
-All employees who have reasonable grounds to suspect that abuse of a resident by anyone happened or may happen in the near future are legally obligated to immediately

report the suspicion and the information upon which it is based to MOHLTC Director.
-Each incident of abuse is to be investigated thoroughly including documentation in accordance with the Chartwell Investigation policy.

a) Staff failed to comply with the policy direction, "all employees who have reasonable grounds to suspect that abuse of a resident by anyone happened are legally obligated to report the suspicion and the information upon which it is based to the Ministry of Long-Term Care Director.

On an identified date a resident told a PSW that they were being rough with them and hurting them and they told the PSW to stop what they were doing. On the same day, when a second PSW completed the care for the resident they told the PSW that the other PSW had been very rough with them, hurt them and they did not want the other PSW to provide care to them anymore. At that time the second PSW noted the resident had a wound that was bleeding. On the same day in the evening the resident reported the situation to a family member and after the family member was notified by registered staff that the resident had a wound that required treatment, the family member contacted the Administrator to find out how to report an incident of resident abuse.

A review of the clinical record, the home’s investigation documents and an interview with the Administrator, it was noted that PSW #140, PSW #136, RPN #143, RPN #142, RN #138 and DOC #139 had reason to suspect the resident had been abused. The identified staff did not report the incident to the Administrator, the registered staff did not contact the Ministry after-hours number and they did not complete a Critical Incident Report.

b) Staff failed to comply with the policy direction that "Each incident of abuse is to be investigated thoroughly including documentation in accordance with the Chartwell Investigation policy when not all staff who had or may have had information about the incident were interviewed as part of the home's investigation.

The Administrator and the home's investigation package related to the incident involving the resident confirmed that the investigation included an interview with the resident, five days after the incident and written statements provided by PSW #140 and PSW #136.

There was no evidence that PSW#140, PSW #136, RPN #138, RPN #143, RPN #142, RN #129 and DOC #139 were interviewed in order to gain a thorough knowledge of the incident and to be able to formulate an outcome/conclusion related to the incident.

Sources: "Abuse Allegations and Follow-Up" policy, home's investigation notes, written statements by PSW #140 and PSW #136, clinical notes, Skin and Pain assessments and interviews with PSW #136 and the Administrator. [s. 20. (1)] (129)

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

The licensee failed to ensure that the temperature of at least two resident rooms were measured and documented at least once every morning, once every afternoon between 1200 hours and 1700 hours and once every evening or night.

A review of temperature monitoring records indicated that registered staff had not measured or documented the temperature in at least two resident rooms during the first 16 days of June 2021.

On June 17, 2021, the Administrator confirmed that staff had not measured or documented the temperature of at least two resident rooms during the first 16 days of June 2021.

This gap in measuring resident room temperatures increased the risk that room temperatures may exceed safe level and place residents at risk of heat related illnesses.

Sources: "Indoor Air Temperature and Humidex Monitoring Records" and an interview with the Administrator [s. 21. (2) 1.] (129)

2. The licensee failed to ensure that required temperatures were measured and documented once every morning, once every afternoon between 1200 and 1700 hours and once every evening or night.

A review of temperature monitoring records indicated that registered staff had not measured or documented the required temperatures once every morning, once every afternoon between 1200 and 1700 hours and once every evening or night during the first 16 days of June 2021.

On June 17, 2021, the Administrator confirmed that staff had not measured or documented the temperature at the required frequency during the first 16 days of June 2021.

This gap in measuring resident room temperatures increased the risk that temperature changes throughout the day, evening and night may exceed safe level and place residents at risk of heat related illnesses.

Sources: "Indoor Air Temperature and Humidex Monitoring Records" and an interview with the Administrator [s. 21. (3)] (129)

Issued on this 12th day of August, 2021

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

Original report signed by the inspector.