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_0003	009704-20, 012575-20, 016551-20, 003263-21, 004114-21, 006488-21	Complaint

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 Complaint 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:
004114-21 and 003263-12 related to falls
006488-21 related to infection prevention and control
016551-20 related to skin and wound
012575-20 related to abuse
009704-20 related to responsive behaviour

PLEASE NOTE:
A Voluntary Plan of Correction related to (LTCHA, 2007, c. 8, s. 33(3) was identified in concurrent inspection #2021_857129_0004 (Log #001202-21, CIS #2921-000005-21) and issued in this report.
A Voluntary Plan of Correction related to O. Reg. 79/10, s. 8(1)(b) was identified in concurrent inspection 857129_0004 (Log #001202-21, CIS #2921-000005-21) and issued in this report.

During the course of the inspection, the inspector(s) spoke with residents, resident family members, Personal Support Workers (PSW), Screeners, PSW Coordinator, Registered Practical Nurses, Registered Nurses, Resident Assessment Instrument Coordinator and the backup Coordinator, Physiotherapist, Assistant Food Services Manager, Business Manager, Environmental Manager, Director of Care #101, Director of Care #102, the Nurse Practitioner and the Administrator.

During the inspection inspectors observed residents, reviewed electronic and paper clinical records, reviewed licensee's policies, reviewed Infection Prevention and Control documents and observed staff IPAC practices.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

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

- **6 WN(s)**
- **5 VPC(s)**
- **1 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. 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 :

1. The licensee failed to ensure that four resident were reassessed and their plans of care reviewed and revised, when their care needs changed.

a) The licensee failed to ensure that a resident's plan of care was reviewed and revised when their care needs changed related to four identified care areas.

The resident #001 experienced a fall in 2021, which resulted in injuries.

A Registered Nurse (RN) verified that prior to the fall the resident walked without assistance and they demonstrated a cognitive impairment.

When the resident returned to the home a protocol was in place that directed the resident was to be isolated in their room for a 14-day period and it was identified that the resident required the assistance of staff to walk and move from their bed and their chair safely.

The clinical record indicated the resident fell twice in the eight days following their return to the home.

Following a review of the resident's care plan, a RN acknowledged that the resident's care plan had not been reviewed or revised when their care needs changed and confirmed, staff felt the resident required one to one monitoring for safety but this care had not been provided, a monitoring plan had not been put in place, a plan was not in place to manage a responsive behaviour demonstrated by the resident related to walking and a plan had not been developed related to the safe use of the washroom for this resident.

Following a review of the resident's care plan, DOC #101, DOC #102 and staff #110 acknowledged that the resident's care plan had not been revised when they returned to the home and it was identified that their care needs had changed.

The failure of staff to revise the resident's care plan when their care needs changed, increased the risk the resident would sustain injuries when they continued to fall upon their return to the home.

Sources: Post Fall Assessments, clinical notes, the resident's care plan and interviews with RN #104, staff #110, DOC #101 and DOC #102. (129)

b) The licensee failed to ensure a resident was reassessed and the plan of care was reviewed and revised when their care needs changed in relation to responsive behaviours.

The resident demonstrated four identified responsive behaviours. The resident's physician had ordered medication that could be administered on an as necessary basis when actions taken by staff had not been effective in managing the behaviours.

The clinical record indicated that actions taken by staff to manage the behaviours had not been effective and there had been an increase in the use of medications to manage the responsive behaviours demonstrated by the resident.

The Medication Administration Record verified that over two-month period, medications to manage the responsive behaviours had been administered ten times more frequently than in the previous month and administered 24 times more frequently in the second month.

A review of the clinical record indicated there had not been a reassessment of the resident until the end of the second month. The Nurse Practitioner (NP) confirmed the resident required a greater frequency of as necessary medications over the identified two-month period. The NP was unable to confirm or provide information to support that the resident had been reassessed when there were increased incidents of responsive behaviours that required use of medications. The NP acknowledged reassessment of use of the medications was warranted to ensure proper care and safety of the resident.

Failure to reassess the resident when their care needs changed, increased the risk to the resident as they experienced an increase in responsive behaviours.

Sources: eMAR and eMAR notes, progress notes, interview with the NP and other staff. (585)

c) The licensee failed to ensure a resident was reassessed and the plan of care reviewed and revised when their care needs changed in relation to oral care.

The resident's written plan of care noted they were able to perform their own hygiene care with set up assistance provided by staff.

Personal Support Worker (PSW) Coordinator #127, PSW #126, and PSW #133 reported the resident experienced a change in ability to perform their own dental hygiene care, approximately 10 months prior to the start of this inspection. Point of Care (POC) documentation, made by PSWs, showed the resident predominately required extensive to total assistance for personal hygiene, which included dental care.

The Resident Assessment Instrument (RAI) Coordinator confirmed the plan of care had not been revised to reflect the change of the resident's care needs related to oral care.

Sources: the resident's written plan of care, POC documentation, interviews with PSW Coordinator #127, PSW #126 and #133 and the RAI-Coordinator. (585)

d) The licensee failed to ensure a resident was reassessed and the plan of care reviewed and revised when their care needs changed in relation to oral care.

The resident's written plan of care directed staff were to provide set up assistance for oral hygiene and the resident would complete their oral care.

Two PSWs reported the resident had required extensive to total assistance with oral care for a long time. Point of Care (POC) documentation, made by PSWs revealed the resident predominately required extensive to total assistance for personal hygiene.

The RAI-Coordinator confirmed the plan of care had not been revised to reflect the change of the resident's care needs related to oral care.

Sources: the resident's written plan of care, POC documentation, interviews with PSW #133, #126 and the RAI-Coordinator. (585) [s. 6. (10) (b)] (129)

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 resident is reassessed and the plan of care is reviewed and revised at least every six months or at any other time when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the policies and procedures included in the required Falls Prevention and Management Program were complied with for two residents.

O. Reg. 48 (1) 1 required the licensee to ensure that an interdisciplinary falls prevention and management program is developed and implemented in the home.

O. Reg. 79/10, s. 30(1) 1 required that for each of the interdisciplinary programs required under section 48 of this regulation there must be a written description of the program that includes relevant policies, procedures and protocols.

The licensee's "Resident Falls Prevention Program", revised on May 31, 2021, directed that for any resident with a score above 12 on the Scott Fall Risk Screening tool, an identifying logo would be located on their mobility aid and at the entrance to their room,

which would easily identify to team members that the resident was at high risk for falling.

a) Staff did not comply with the home's "Resident Falls Prevention Program" when they did not place the identifying logos on a resident's mobility aid or at the entrance to their room, in order to identify to team members the resident was at risk for falling.

The resident experienced multiple falls and during one incident they sustained injuries that required them to be transferred to hospital.

At the time of this inspection, the most recent Scott Fall Risk Screening tool completed indicated the resident had a scored of 13 and was at high risk for falling.

Observations made at the time of this inspection, confirmed there was not a logo on the resident's mobility aid or at the entrance to their room.

DOC #101, Registered Nurse (RN) #104 and Registered Practical Nurse (RPN) #124 confirmed that the logo program was not currently in place in the home.

The failure of staff to use the logo to alert staff and others that the resident was at high risk for falling, increased the risk that the resident could be placed in situations that may result in them falling and possibly injuring themselves.

Sources: observations of the resident's environment, electronic fall risk screening tools, interview with DOC #101, RN #104 and RPN #124 as well as the licensee's "Resident Fall Prevention Program" documents.

b) Staff did not comply with the home's "Resident Falls Prevention Program" when they did not place the identifying logos on a resident's mobility aid or at the entrance to their room, in order to identify to team members that the resident was at risk for falling.

The resident experienced multiple falls and during one incident they sustained an injury that required them to be transferred to hospital.

At the time of this inspection, the most recent Scott Fall Risk Screening tool completed for the resident indicated the resident had a scored of 15 and was at high risk for falling.

Observations made at the time of this inspection, identified there was not a logo on the resident's mobility aid or at the entrance to their room.

DOC #101, RN #104 and RPN #124 confirmed that the logo program was not currently in place in the home.

The failure of staff to use falling star logo to alert staff and others that the resident had been identified at high risk for falling, increased the risk that the resident could be placed in situations that may result in the resident falling and injuring themselves.

Sources: observations of the resident's environment, electronic fall risk screening tools, interview with DOC #101, RN #104 and RPN #124 as well as the licensee's "Resident Fall Prevention Program" document.

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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a Personal Assistance Services Device (PASD) described in subsection 33 (1) of the LTCHA, satisfied the requirements in subsection 33(4) of the LTCHA, before it was included in three residents plans of care.

LTCHA, 2007, c. 8, s. 33(1) This section applies to the use of a PASD if the PASD has the effect of limiting or inhibiting a residents freedom of movement and the resident is not able to, either physically or cognitively release themselves from the PASD.

LTCHA, 2007, c. 8, s 33 (4) This sections directs; the use of a PASD under subsection (3) may only be included in the resident's plan of care if the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living.
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations.
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
5. The plan of care provides for everything required under subsection (5).

a) A resident used a mobility aid and staff indicated that when the aid was positioned in a specific way the resident's mobility was limited and inhabited.

A referral note made by the Physiotherapist indicated the mobility aid was needed for the resident as a Personal Assistance Services Device (PASD) for comfort and positioning as well as to reduce the risk for skin breakdown.

On an identified date, at the time of this inspection, the resident was observed to be using the mobility aid and it was positioned in a way that limited and inhibited their freedom of movement.

Several days later, the resident was observed to be using the aid in the morning and in the afternoon. On both occasions the aid was positioned in a way that limited and

inhibited their freedom of movement.

At the time of these observations, a PSW indicated the resident’s freedom of movement was limited and inhibited by the mobility aid and that the resident used the aid during the entire shift.

During an interview with the Physiotherapist, they confirmed they had not considered or conducted trials of alternatives to the mobility aid used by the resident that limited and inhibited the resident's freedom of movement.

Failure of staff to consider or trial alternatives to the use of the mobility aid resulted in the resident's freedom of movement being both limited and inhibited and also negatively affected their ability to socialize during the times when their aid was positioned.

Sources: observations of the resident, electronic clinical records and interviews with PSW #131 and the Physiotherapist.

b) A resident used a mobility aid and staff indicated that when the aid was positioned in a specific way the resident’s mobility was limited and inhabited.

A clinical note made by the Physiotherapist indicated that they were able to provide the resident with a mobility aid to be used as a PASD for comfort, to improve sitting tolerance, allow for positioning and reduce the risk of skin breakdown.

The resident's care plan included a care focus, a care goal and care interventions related to the use of the mobility aid as a PASD.

On an identified day, the resident was observed to be using the mobility aid and the aid had been positioned in such a way that it limited and inhibited the resident’s freedom of movement. At the time of this observation a PSW confirmed that the resident‘s freedom of movement was limited and inhibited when the aid was positioned as it was observed.

The following day the resident was again noted to be using the mobility aid that had been positioned in such a way to limit and inhibit the resident’s freedom of movement.

During an interview with the Physiotherapist, they confirmed that they had not considered or conducted trails of alternatives to the use the mobility aid being used by the resident

that limited and inhibited the resident's freedom of movement.

A review of the hard copy clinical record indicated there was no evidence that a consent for the use of the PASD had been obtained prior to its use and this was confirmed by DOC #101.

Failure of staff to consider or trial alternatives to the mobility aid used for the resident and failure of staff to gain consent for the use of the aid, resulted in the resident's freedom of movement being both limited and inhibited, a negative affect to their ability to socialize during times when their mobility aid was positioned and prevented their Substitute Decision Maker (SDM) from participating in decision making about the resident's care.

Sources: observations of the resident, the electronic care plan and clinical notes, the hard copy clinical record and interviews with PSW #131, the Physiotherapist and DOC #101.

c) A resident used a mobility aid and staff indicated that when the aid was positioned in a specific way the resident’s freedom of movement was limited and inhibited.
.
The Physiotherapist wrote a clinical note and indicated the resident required the use of the mobility aid as PASD for comfort to increase sitting tolerance and to reduce the risk of skin breakdown.

The resident's care plan included a care focus, a care goal and care interventions related to the use of the mobility aid as a PASD.

During the inspection the resident was observed once in the morning and once in the afternoon of the same day, to be using the mobility aid that had been positioned in a way that limited and inhibit their freedom of movement. During the afternoon observations, the resident was noted to struggle unsuccessfully on two occasions to move away from the mobility aid.

During an interview with the Physiotherapist, they confirmed that they had not considered or conducted trials of alternatives to the use of the mobility aid that limited and inhibited the resident’s freedom of movement.

Failure of staff to consider or trial alternatives to the use of the mobility aid resulted in the resident's freedom of movement being both limited and inhibited and negatively affected

their ability to socialize when the aid was positioned.

Sources: observations of the resident, the electronic care plan, clinical notes and interviews with PSW #131 and the Physiotherapist. [s. 33. (3)] (129)

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 a PASD described in subsection 33(1) of the LTCHA is only included in the resident's plan of care if all of the requirements identified in subsection 33(4) of the LTCHA have been satisfied, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 174.1 Directives by Minister

Specifically failed to comply with the following:

s. 174.1 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home. 2017, c. 25, Sched. 5, s. 49.

Findings/Faits saillants :

The licensee failed to ensure that every operational directive that applies to the long-term care home was complied with in relation to the Minister's Directive: COVID-19 Long-Term Care Home Surveillance Testing and Access to Homes.

The Minister's Directive referenced the Ontario Ministry of Health (MOH)'s COVID-19 Guidance: Considerations for Antigen Point-of-Care Testing, which directed specimen collection must be conducted in accordance with the kit instructions for use.

The home used Panbio COVID 19 Ag Rapid Test for Antigen testing system, which specified results were to be interpreted no longer than 20 minutes after the test.

The home's Antigen Test log noted an Antigen test was conducted on a resident's caregiver at 1805 hours, on an identified date. As permitted under the Minister's Directive, the caregiver proceeded into the home to provide care to the resident prior to receiving the results of the Antigen test.

Staff #130 reported at the end of their shift on the above noted date that they collected the caregiver's specimen, communicated to a RN that the test result was pending and left the home.

The RN reported they could not recall being made aware of the pending Antigen test.

According to the Administrator, the Antigen test was interpreted by staff hours after it was conducted and when read indicated a positive test result. The Administrator reported the home did not contact the local Public Health unit to inform them of the positive test result. The local Public Health unit confirmed the home was required to inform them of the positive result and confirmed this was not done.

Failure to interpret the results in the appropriate time frame increased potential risk to the resident.

Sources: Minister's Directive: COVID-19 Long-Term Care Home Surveillance Testing and Access to Homes; Ministry of Health (MOH)'s COVID-19 Guidance: Considerations for Antigen Point-of-Care Testing Version 4.0 March 19, 2021, Antigen Test log, interview with screener #130, RN #115, the Administrator and PH.

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 operational or policy directive, issued by the Minister that applies to long-term care homes is carried out, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control (IPAC) program in relation to resident hand hygiene during snacks.

The home's hand hygiene policy stated, "residents are encouraged to engage in frequent hand hygiene. For example, encouragement of residents to use (ANBR) alcohol based when entering and leaving the dining room for a meal."

On May 17, 2021, afternoon snack pass was observed on Scenic Woods and Old Mill home areas. Two PSWs confirmed residents were not offered hand hygiene prior to receiving their snacks.

On May 18, 2021, afternoon snack pass was observed on Battlefield home area. A PSW confirmed residents were not offered hand hygiene prior to receiving their snacks.

The Administrator reported the home followed the "Just Clean Your Hands Program", and it was an expectation that residents who would be eating independently, would be offered hand hygiene before and after meals and snacks.

Not offering hand hygiene increased risk to residents as it served as a mechanism to prevent the transmission of infection.

Sources: the home's policy, "Hand Hygiene Program - Policy No: LTC-CA-WQ-205-02-04", revised March 2020, three snack observations, interviews with PSW #108, #116, #118 and the Administrator. [s. 229. (4)]

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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, the skin alteration was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The clinical record indicated that the resident had an open skin area. New orders were initiated which included weekly skin assessments, treatment creams were ordered to be applied to the area and weekly assessments and treatment orders were active for a three-month period.

Skin assessments were not completed weekly as indicated on five occasions during the three-month period.

The clinical record did not show that condition of the wound deteriorated; however, there was no record to indicate the wound had resolved. DOC #101 and #102 confirmed weekly skin assessments were not completed weekly when required for resident #005.

Sources: the resident's eMAR and eTAR, weekly skin assessments, interview with DOC #101 and #102.

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.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	PHYLLIS HILTZ-BONTJE (129), LEAH CURLE (585)
Inspection No. / No de l’inspection :	2021_857129_0003
Log No. / No de registre :	009704-20, 012575-20, 016551-20, 003263-21, 004114-21, 006488-21
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 29, 2021
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
LTC Home / Foyer de SLD :	Chartwell Willowgrove Long Term Care Residence 1217 Old Mohawk Road, Ancaster, ON, L9K-1P6
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Kate MacDonald

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

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:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee must comply with s. 6(10) of the LTCHA 2007.

Specifically, the licensee shall:

1. Provide training for all registered staff who work on the Flamborough home area related to the process and expectations for reassessing residents as well as the review and when necessary, the revision the plan of care for residents who return from hospital.

2. Maintain training records including the content of the training provided and the names of persons who attended.

3. Develop and implement an auditing tool to ensure the process identified in the training has been complied with. Documentation of the completed audits are to be maintained and the auditing is to continue until no further concerns arise.

Grounds / Motifs :

1. The licensee failed to ensure a resident's plan of care was reviewed and revised when their care needs changed related to four identified care areas.

The resident experienced a fall in 2021, which resulted in two injuries.

A Registered Nurse (RN) verified that prior to the fall the resident walked without assistance and they demonstrated a cognitive impairment.

When the resident returned to the home a protocol was in place that directed the resident was to be isolated in their room for a 14-day period and it was identified that the resident required the assistance of staff to walk and move from their bed and their chair safely.

The clinical record indicated the resident fell twice in the eight days following their return to the home.

Following a review of the resident's care plan, a RN acknowledged that the resident's care plan had not been reviewed or revised when their care needs changed and confirmed, staff felt the resident required one to one monitoring for safety but this care had not been provided, a monitoring plan had not been put in place, a plan was not in place to manage a responsive behaviour demonstrated by the resident related to walking and a plan had not been developed related to safe use of the washroom for this resident.

Following a review of the resident's care plan, two DOCs and a staff member acknowledged that the resident's care plan had not been revised when they returned to the home and it was identified that their care needs had changed.

The failure of staff to revise the resident's care plan when their care needs changed, increased the risk the resident would sustain injuries when they continued to fall upon their return to the home.

Sources: Post Fall Assessments, clinical notes, the resident's care plan and interviews with RN #104, staff #110, DOC #101 and DOC #102.

An order was made taking the following factors into account:

Severity: The resident's care plan was not revised, to address changes in their care need related to four care areas. There was actual risk of harm and further injury when the resident experienced two falls on the seventh and eighth day, following their return to the home.

Scope: The scope of this non-compliance was a pattern because the review and revision of resident's care plans when their care needs changed did not occur for four of nine residents who were reviewed during this inspection. Voluntary Plans of Correction were issued for this section related to three other residents and can be found in the Licensee Report under Written Notification (WN) #1.

Compliance History: A written notification (WN) was issued for s. 6 (10) (b) of the LTCHA 2007, on July 19, 2018, during inspection #2018_543561_0009. In addition, two WNs and two Voluntary Plans of Correction (VPC) were issued to the home related to different sections of the legislation in the past 36 months. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 29, 2021

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 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

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère 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 29th day of July, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE

Service Area Office /
Bureau régional de services : Hamilton Service Area Office