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
Apr 20, 2022	2022_823653_0009	012801-21, 014231-21, 014290-21, 019346-21, 001026-22	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

ROMELA VILLASPIR (653), JESSICA BERTRAND (722374), NUZHAT UDDIN (532)

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): March 24-25, 28-31, and April 1, 2022.

The following intakes were inspected in this complaint inspection:

Logs #014231-21 and #014290-21 were related to an allegation of resident neglect;
Log #019346-21 was related to residents' bill of rights, and an allegation of resident neglect;
Log #001026-22 was related to pain and medication management, weight loss, and complaint procedures;
Log #012801-21 was related to Compliance Order (CO) #001 issued on July 29, 2021, within report #2021_857129_0003, related to Long-Term Care Homes Act (LTCHA), 2007, s. 6 (10).

During the course of the inspection, the inspector(s) spoke with the residents, Substitute Decision-Makers (SDMs), Personal Support Workers (PSWs), Agency PSWs, Registered Practical Nurses (RPNs), Agency RPNs, Registered Nurses (RNs), Resident Assessment Instrument (RAI)-Minimum Data Set (MDS) Co-ordinator, PSW Co-ordinator, Housekeeper, Registered Dietitian (RD), Physician, Infection Prevention and Control (IPAC) Lead, Assistant Director of Care (ADOC), Director of Care (DOC), and the Administrator.

During the course of the inspection, the inspectors toured the home, observed IPAC practices, meal services, provision of care, reviewed clinical health records, staffing schedules, the home's investigation notes, staff training records, complaint records, compliance order binder, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **3 VPC(s)**
- **0 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
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2021_857129_0003	653

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care for two residents, collaborated with each other in the development and implementation of the plan of care, so that the different aspects of care were integrated and were consistent with and complemented each other, related to the residents' continence care.

A resident required assistance from staff members for continence care.

Two Registered Practical Nurses (RPNs) indicated that it was not safe for the resident to receive a specific intervention related to continence care and management.

Three PSWs indicated that the resident was provided the specified intervention related to continence care.

The PSW Co-ordinator indicated that they were responsible for ordering a specific equipment for residents who required them for care, as the size had to be individualized for each resident. The PSW Co-ordinator was not aware that the PSWs used the specific equipment for the resident, and that they provide the specified intervention related to continence care.

By not collaborating with each other in the development and implementation of the

resident's plan of care, there was a potential safety risk with regards to the resident's continence care and management.

Sources: Resident's clinical health records; Interviews with PSWs, RPNs, the PSW Co-ordinator, Assistant Director of Care (ADOC), and the Director of Care (DOC). [s. 6. (4) (b)]

2. Staff were to provide assistance to a resident for continence care, and apply a specific product after elimination. During Inspector #653's observation, a PSW assisted the resident with continence care and did not apply the product identified in their care plan. The PSW indicated to the inspector that they had been applying a different product as the resident's continence care needs changed.

The ADOC indicated that the PSW should have reported to the RPN if there were changes in the resident's incontinence status, and that the care plan and product list that the PSWs referred to, should have been updated to reflect the current care needs of the resident.

By not collaborating with each other in the development and implementation of the resident's plan of care, there was potential for other staff to use an incorrect continence care product on the resident.

Sources: Resident's clinical health records; Inspector #653's observation; Interviews with a PSW, RPN, the Resident Assessment Instrument (RAI)-Minimum Data Set (MDS) Co-ordinator, PSW Co-ordinator, and the ADOC. [s. 6. (4) (b)]

3. The licensee has failed to ensure that the SDMs of two residents, were given an opportunity to participate fully in the development and implementation of the residents' plan of care.

A complaint was received by the Ministry of Long-Term Care (MLTC) related to multiple concerns for a resident, including not notifying the SDM when changes were made to the resident's care plan.

Following an assessment by a Registered Dietitian (RD), changes were made to the resident's care plan, and the resident's SDM was not notified of the changes until five days after. A RPN confirmed that changes should have been discussed with the resident's SDM at the time of the change.

Sources: Resident's progress notes and care plan; Interview with a RPN. [s. 6. (5)]

4. A complaint was received by the MLTC related to a resident’s medication and pain management.

A resident had a medical condition, and a consultation report from a specialist recommended to reduce one medication at a time, and titrate down if possible.

The consultation report gave specific instructions stating that the medication should not be stopped, as there could be flare-up of the resident’s medical condition if it is stopped suddenly.

Details of a hospital report stated that the resident was admitted with an infection, and their medications were adjusted. Three months later, the resident's medication was stopped abruptly, which may have contributed to the flare-up of their medical condition, and the significant weight loss they experienced in a span of six months.

The SDM questioned the dose changes as they were not made aware, and not given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The ADOC and the physician acknowledged that due to not having consistent registered staff over the past two years, there were communication break down between the interdisciplinary team.

The ADOC and the DOC acknowledged that the SDM may not have been provided the opportunity to participate fully in the development and implementation of the resident's plan of care.

Sources: Resident's eMAR, progress notes, plan of care, assessments, written complaint; Interviews with the SDM, physician, Registered Dietitian (RD), pharmacist, the ADOC, DOC, and the Administrator. [s. 6. (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 to ensure
-that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other;
-that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the verbal and written complaints made to the licensee or a staff member concerning the care of a resident, had been investigated, resolved where possible, and a response was provided within 10 business days of receipt of the complaint, and where the complaint alleged harm or risk of harm to the resident, that the investigation commenced immediately.

A verbal complaint was received by the home related to a resident’s medication changes, and pain management.

A three and a half page complaint regarding the resident's care, was e-mailed to the Administrator of the home, detailing abrupt medication changes, and significant weight loss, with no notification to the resident's SDM.

The Administrator stated that they did not consider the e-mail as a written complaint since the SDM declined to have their complaint escalated to the MLTC, and did not resolve or provide a response within 10 business days of receipt of the complaint.

The SDM stated that they were looking for a formal response as no one had responded to their written complaint.

By not investigating and resolving the concerns outlined in the SDM's complaint, and by not providing a response within 10 business days of receipt of the complaint, there was mistrust and further concerns with the family.

Sources: The home's complaint records; Interviews with the resident's SDM, and the Administrator. [s. 101. (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 to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately, to be implemented voluntarily.

WN #3: 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 has failed to ensure that staff participated in the implementation of the home’s Infection Prevention and Control (IPAC) program, including proper donning and doffing of Personal Protective Equipment (PPE) when entering a resident room on droplet and contact precautions, clear signage indicating additional precautions, and assisting or encouraging residents to perform hand hygiene before eating.

The home’s policy titled "Routine Practices and Additional Precautions" stated that droplet and contact precautions were required for pathogens that could survive in an environment for a period of time. When droplet precautions were in place, staff must also wear gloves, gowns, eye protection, and a mask, including N95 respirators when indicated by direction of the Health Unit.

The home’s policy titled "Hand Hygiene Program" stated residents were encouraged to engage in frequent hand hygiene, including hand hygiene to be performed before eating food.

A) A resident required droplet and contact precautions, and staff were required to don PPE including a gown, N95 mask, face shield, and gloves when entering the resident's room, and droplet and contact precautions signage was to be posted.

During Inspector #722374's observation, a leadership team member was observed wearing a surgical mask and entered the resident's room without donning and doffing gloves, a gown, N95 mask or a face shield. Signage displayed on the resident's room did not specify the additional precautions that were required. The leadership team member confirmed they did not enter the resident's room with appropriate PPE.

B) During Inspector #722374's observation, a PSW provided snacks to five residents in their rooms, and was observed not to provide or assist those residents with completing hand hygiene prior to eating. The PSW indicated they should have provided alcohol-based hand rub to these residents.

Failing to ensure that staff participated in the home's IPAC program in relation to the correct use of PPE, signage posted indicating additional precautions in place, and resident hand hygiene at snack times may increase the spread of infection throughout the home.

Sources: The home's Routine Practices and Additional Precautions policy, and Hand Hygiene Program policy; Inspector #722374's observations; Interviews with the IPAC Lead, and other staff. [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 to ensure that all staff participate in the implementation of the home's Infection Prevention and Control program, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected their dignity, was fully respected and promoted.

A resident required staff assistance for continence care. Two PSWs indicated that staff would assist the resident with toileting in a specified manner.

The PSW Co-ordinator, ADOC, and the DOC acknowledged that the manner in which PSWs assisted the resident with toileting, did not fully respect the resident's dignity.

Sources: Resident's clinical health records; Interviews with PSWs, PSW Co-ordinator, ADOC, and the DOC. [s. 3. (1) 1.]

WN #5: 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 has failed to ensure that strategies included in the pain management program were complied with for a resident.

Ontario Regulation (O. Reg.) 79/10, s. 48 (1) requires a pain management program to identify and manage pain in residents.

O. Reg. 79/10, s. 52 (1) requires that the program provides strategies to manage pain, including non-pharmacological interventions.

Specifically, the staff did not comply with the home’s policy titled "Pain".

The policy stated that where the evaluation indicates the treatment was not effective, registered staff will reassess the pain and try other alternatives including non-pharmacological interventions, including massage, heat or cold, distraction (television, music, activity), acupuncture by licensed provider, re-positioning, progressive relaxation or deep breathing.

A complaint was received by the MLTC related to multiple care concerns for a resident, including pain management.

Upon admission, the resident was identified as having general pain due to a medical condition, with interventions included in the plan of care.

On one occasion, the resident was noted to have pain. The resident was provided medication for their pain and after two hours, it was noted that the medication was not effective as the resident continued to moan in pain. No other interventions were taken at that time, and the next pain assessment was completed seven days later.

When the resident continued to exhibit pain after receiving pain medication, other interventions, including non-pharmacological interventions, were not tried.

Sources: Resident's progress notes, care plan, pain assessments, electronic Medication Administration Record (eMAR), the home's Pain policy; Interviews with a Registered Nurse (RN) and RPN. [s. 8. (1)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that they immediately forwarded a written complaint they received concerning the care of a resident, to the Director.

A three and a half page complaint regarding a resident's care, was e-mailed to the Administrator of the home, detailing abrupt medication changes, and significant weight loss, with no notification to the resident's SDM.

The Administrator stated that they did not consider the e-mail as a written complaint since the SDM declined to have their complaint escalated to the MLTC, and did not immediately forward the written complaint concerning the care of the resident to the Director.

Sources: The home's complaint records; Interviews with the resident's SDM, and the Administrator. [s. 22. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure a resident was dressed appropriately, suitable to the time of day, and in keeping with their preferences.

A resident required staff assistance to adjust their clothing.

During Inspector #722374's observation, the resident was observed to be wearing pajamas during the meal service in the dining room. The resident said they did not want to be in their pajamas but were told by staff to put them on. The Administrator confirmed that residents should not be in their pajamas during a meal service if they do not want to be.

By not helping the resident dress in clothes appropriate for the meal service, the staff did not take the resident's preference into account.

Sources: Inspector #722374's observations; Resident's care plan; Interviews with the resident, a PSW, and the Administrator. [s. 40.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who was incontinent, received an assessment that included identifications of causal factors, patterns, type of incontinence, and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Upon admission of a resident to the home, the resident was wearing a continence care product and were noted to be incontinent.

The ADOC reviewed the resident's Point Click Care (PCC) assessments and confirmed that the bladder continence and bowel function assessments were not completed ever since the resident was admitted to the home.

By not completing an assessment, there was potential for staff to not identify and meet the resident's continence care needs.

Sources: Resident's clinical health records; Interviews with a RPN, the RAI-MDS Co-ordinator, and the ADOC. [s. 51. (2) (a)]

2. The licensee has failed to ensure that a resident who was incontinent, had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment of their incontinence.

A resident's bladder continence and bowel function assessments indicated that the resident was incontinent of bladder and bowel, and they required a specific intervention to manage their continence care.

The resident's care plan did not provide clear direction as to when the specific intervention should be provided.

The ADOC indicated that the care plan must be individualized and indicate the times when staff would provide the specific intervention for continence care and management, as determined in the assessment.

By not having an individualized plan of care for continence, there was potential for the PSWs to not consistently provide the assistance required by the resident for continence care.

Sources: Resident's clinical health records; Interviews with the PSWs, the RAI-MDS Co-ordinator, ADOC, and the DOC. [s. 51. (2) (b)]

Issued on this 22nd day of April, 2022

[redacted]

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

Original report signed by the inspector.