

**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**

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
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Bureau régional de services de
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33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 2, 2021	2021_814501_0005	011528-20, 019793-20	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 Woodhaven Long Term Care Residence
380 Church Street Markham ON L6B 1E1

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

SUSAN SEMEREDY (501)

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): February 4, 5, 9, 10, 11, 12, 2021.

**The following intakes were inspected in this critical incident inspection:
Log #019793-20 related to safe transferring; and,
Log #011528-20 a Follow-up to CO#001 from inspection #2020_814501_0004 related to collaboration in the plan of care with a compliance due date of December 11, 2020.**

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care, Food Service Manager (FSM), Assistant Food Service Manager (Assistant FSM), Registered Dietitian (RD), registered practical nurses (RPNs), personal care providers (PCPs), dietary aides, housekeepers, and residents.

During the course of this inspection the inspector observed infection prevention and control practices, resident and staff interactions, the provision of care, and reviewed resident clinical records, diet lists, diet spreadsheets and the home's investigation notes.

**The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services**

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

3 WN(s)

2 VPC(s)

1 CO(s)

0 DR(s)

0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:

Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / DE L'INSPECTION	NO NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (4)	CO #001	2020_814501_0004	501

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
<p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure resident #001 and #002 were provided menu items as specified in their plan of care.

Resident #001 was to receive an individualized menu due to medical issues. It was observed that the resident received an entrée that was not part of this menu. Interviews with the RD and an RPN indicated the resident should not have received this menu item due to medical issues.

Providing resident #001 with menu items that were not part of their individualized menu put them at risk for developing indigestion and pain.

Sources: Resident #001's clinical record and individualized menu, the home's diet list, observation at mealtime and interviews with the RD and other staff members. [s. 6. (7)]

2. Resident #002 was not to receive specific menu items due to medical issues. It was observed the resident received one of these menu items as was confirmed by a PCP. A dietary aide indicated that the menu item that should have been served was not available. Interviews with the FSM and Assistant FSM indicated the resident should not have received such an item and the menu item that should have been served was available.

Failing to provide resident #002 with menu items according to their plan of care put them at risk for developing discomfort related to indigestion.

Sources: Resident #002's clinical record, the home's diet list and therapeutic spreadsheet, observation at mealtime and interviews with FSM, Assistant FSM and other staff members. [s. 6. (7)]

3. The licensee failed to ensure resident #002 received an intervention as specified in their plan of care.

Resident #002 was known to have responsive behaviours and due to an incident was to have an intervention to prevent recurrence until further notice. An observation indicated the resident was not provided this intervention and was expressing responsive behaviours. Interviews with staff members confirmed the intervention was not provided. An RPN indicated resident #002 often has responsive behaviours and other residents are fearful.

Failing to provide resident #002 with the care set out in their plan of care put them and other residents at risk for further incidents and risk of harm.

Sources: Resident #002's clinical records including progress notes, observation and interviews with an RPN and other staff members. [s. 6. (7)]

Additional Required Actions:

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

WN #2: 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.**
- 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.**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident.**
- 4. Misuse or misappropriation of a resident's money.**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.**

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper care of resident #002 resulted in harm was immediately reported to the Director.

A Critical Incident System (CIS) report indicated resident #002 complained of an injury due to being improperly transferred. The report indicated that the incident was called in to the after-hours line. An interview with the DOC indicated they were not sure why the previous DOC waited two days to report the incident as staff suspected the injury occurred due to an improper transfer as early as the same day it occurred.

Failing to immediately report improper care of a resident to the Director puts residents at continued risk of harm.

Sources: CIS report and interview with the DOC. [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 to ensure that a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident shall immediately report the suspicion, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure a PCP used safe transferring techniques when assisting resident #002.

Resident #002 complained of an injury and stated they had a fall when a staff member transferred them. Resident #002's care plan indicated they were to be provided total assistance with two staff using an assistive device due to a recent injury. The home's investigation found that a PCP performed a transfer on their own without using an assistive device.

Failing to provide the resident with proper transferring techniques resulted in injury and put the resident at risk for serious harm.

Sources: CIS report, resident #002's clinical record, the home's investigation notes and interviews with the DOC and other staff members. [s. 36.]

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 staff use safe transferring techniques when assisting residents, to be implemented voluntarily.

Issued on this 4th day of March, 2021

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

Original report signed by the inspector.

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

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) : SUSAN SEMEREDY (501)

Inspection No. /

No de l'inspection : 2021_814501_0005

Log No. /

No de registre : 011528-20, 019793-20

Type of Inspection /

Genre d'inspection: Critical Incident System

Report Date(s) /

Date(s) du Rapport : Mar 2, 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 Woodhaven Long Term Care Residence
380 Church Street, Markham, ON, L6B-1E1

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : Andre Dwyer

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:

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the LTCHA.

Specifically, the licensee must:

1. Ensure resident #001 and #002 are provided menu items as specified in their plan of care.
2. Ensure staff members provide interventions for responsive behaviours for resident #002 as indicated in their plan of care.

Grounds / Motifs :

1. The licensee failed to ensure resident #001 and #002 were provided menu items as specified in their plan of care.

Resident #001 was to receive an individualized menu due to medical issues. It was observed that the resident received an entrée that was not part of this menu. Interviews with the RD and an RPN indicated the resident should not have received this menu item due to medical issues.

Providing resident #001 with menu items that were not part of their individualized menu put them at risk for developing indigestion and pain.

Sources: Resident #001's clinical record and individualized menu, the home's diet list, observation at mealtime and interviews with the RD and other staff members. (501)

2. Resident #002 was not to receive specific menu items due to medical issues. It was observed the resident received one of these menu items as was confirmed by a PCP. A dietary aide indicated that the menu item that should

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

have been served was not available. Interviews with the FSM and Assistant FSM indicated the resident should not have received such an item and the menu item that should have been served was available.

Failing to provide resident #002 with menu items according to their plan of care put them at risk for developing discomfort related to indigestion.

Sources: Resident #002's clinical record, the home's diet list and therapeutic spreadsheet, observation at mealtime and interviews with FSM, Assistant FSM and other staff members. (501)

3. The licensee failed to ensure resident #002 received an intervention as specified in their plan of care.

Resident #002 was known to have responsive behaviours and due to an incident was to have an intervention to prevent recurrence until further notice. An observation indicated the resident was not provided this intervention and was expressing responsive behaviours. Interviews with staff members confirmed the intervention was not provided. An RPN indicated resident #002 often has responsive behaviours and other residents are fearful.

Failing to provide resident #002 with the care set out in their plan of care put them and other residents at risk for further incidents and risk of harm.

Sources: Resident #002's clinical records including progress notes, observation and interviews with an RPN and other staff members.

An order was made by taking the following factors into account:

Severity: There was minimal risk to residents #001 and #002 for not receiving menu items as specified in their plan of care. There was actual risk of harm to residents when resident #002 was not provided an intervention as specified in their plan of care.

Scope: The scope of this non-compliance was a pattern as it affected two out of three residents.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 6 (7) and five written notifications (WNs), three voluntary plans of correction (VPCs) and two compliance orders (COs) were issued.

(501)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le :

Jun 30, 2021

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

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l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

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:

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

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.

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

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2007, chap. 8

**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, 11^e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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 révision
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 2nd day of March, 2021

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : Susan Semeredy

Service Area Office /

Bureau régional de services : Central East Service Area Office