Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 26, 2018	2018_598570_0001	009726-17, 016209-17, 017705-17, 020145-17, 022159-17, 022163-17, 024994-17	Critical Incident System

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

Long-Term Care Home/Foyer de soins de longue durée

Chartwell Wynfield Long Term Care Residence
451 Woodmount Drive OSHAWA ON L1G 8E3

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

SAMI JAROUR (570), CRISTINA MONTOYA (461)

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): January 2, 3, 4 and 5, 2018

The following logs were inspected:
- Log #009726-17 related to an allegation of neglect.
- Log #016209-17 related to an allegation of physical abuse of a resident.
- Log #020145-17 related to an incident of missing resident.
- Log #017705-17, Log #021057-17, Log #022159-17, Log #022163-17 and Log #024994-17 related to falls that resulted in an injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Program Manager, MDS-RAI Coordinator, Recreation Aides, Registered Practical Nurses (RPN), Personal Care Providers (PCP) and residents.

During the course of the inspection, the inspector(s) toured resident home areas, observed staff to resident interactions and resident to resident interaction; reviewed resident's health records, the licensee's internal investigations and the licensee's policy related to falls prevention and management.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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. (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 has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan, related to responsive behaviors.

Related to Log #020145-17

A critical incident report (CIR) was submitted to the Director on an identified date for a missing resident incident less than three hours involving resident #001.

Resident #001 was admitted to the home on an identified date with multiple diagnoses including cognitive decline.

Review of progress notes for resident #001 indicated the resident had eloped from the Long -Term Care (LTC) home on two occasions as follows:
- On an identified date, the resident was found by a family member of a co resident a few blocks away from the LTC home. The resident had fallen and sustained an injury. The family member returned the resident to the home.
- Ten days following previous incident, the resident was found by a visitor unsupervised outside the LTC home. The resident stated they had a fall and complained of pain to a specified area.

Review of resident #001's plan of care, in place at the time of the above incidents, indicated the resident was at risk of elopement. The plan of care directed staff that resident #001 was to be supervised when leaving the home area and not to exit outside of the home unsupervised.

During an interview with the Director of Care (DOC), indicated to Inspector #570 that resident #001 had a history of elopement and was at risk of elopement. The DOC indicated that the recreation staff should communicate when taking a resident, who is at risk of elopement or exit seeking, to a program outside of the resident's home area. During the same interview, the DOC confirmed to Inspector #570 that resident #001 was not supervised as per resident #001's plan of care when the resident managed to exit the home on two identified dates.

During an interview with the program manager, indicated to Inspector #570 that on an identified date, RPN #111 brought the resident to an event and did not alert recreation staff. During the event, it was not possible for recreation staff to supervise resident #001 one to one.

Resident #001 was not provided care as specified in the plan of care when the resident was not supervised after leaving the home area resulting in the resident exiting the LTC

home on two occasions. [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #007 as specified in the plan related to falls prevention and management.

Related to Log #024994-17

A critical incident report (CIR) was received by the Director on an identified date for a fall incident, involving resident #007, that resulted in an injury and for which the resident was transferred to hospital.

Resident #007 had diagnoses that included cognition impairment. The resident had been identified as a high risk for falls.

Review of the CIR notes and progress notes for resident #007 indicated on an identified date, resident #007 was found on floor at the end of bed. The resident was assessed and was transferred to hospital.
One day later, the resident was diagnosed with an injury to a specified area

Review of resident #007's current plan of care indicated:
- High risk for falls due to cognitive impairment, increased confusion, abandoning mobility aid at times, pain in identified body parts, and daily use of specified medications.
- Ensure appropriate safety devices use: currently uses three identified falls prevention and management interventions.

During an observation and interview with resident #007, the resident indicated to Inspector #570 that they chose to stay in bed for on identified meal. Inspector #570 noted one identified falls intervention not in use.

During an interview, Personal Care Provider (PCP) #109 indicated to Inspector #570 that resident #007 was at high risk for falls and had interventions in place for falls prevention. PCP #109 further indicated that the identified falls prevention intervention was not in place when the resident was in bed.

During an interview, Registered Practical Nurse (RPN) #110 indicated to Inspector #570 that resident #007 was at high risk for falls due to history of falls and multiple diagnosis. The RPN further indicated that multiple interventions were utilized for resident #007 for falls prevention. The RPN confirmed to the Inspector that the identified falls prevention

intervention was not in place while the resident was in bed as directed in the plan of care.

Resident #007 was not provided care as specified in the plan of care related to the use of an identified falls intervention, as part of the falls management interventions for the resident. [s. 6. (7)]

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 care is provided to residents as specified in the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written report submitted to the Director within 10 days of becoming aware of the incident described in r. 107 (1), (3) or (3.1), included the following with respect to the incident:
v. the outcome or current status of the individual or individuals who were involved in the incident.

Related to Log #021057-17

A critical incident report (CIR) was received by the Director on an identified date for a fall incident, that occurred two days earlier involving resident #004, that resulted in an injury and for which the resident was transferred to hospital.

Review of the CIR notes and progress notes for resident #004 indicated: On identified date and time, the resident was found on the floor. The resident sustained an injury to two identified body parts. The resident was transferred to hospital for further assessment. The resident was diagnosed with an injury and was deceased one day after the report was submitted to the Director.

On January 4, 2018, during an interview, the DOC indicated to Inspector #570 that the CIR was not updated regarding the status of the resident until approximately two months after the change of status of the resident. [s. 107. (4) 3.]

Issued on this 5th day of February, 2018

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

Original report signed by the inspector.