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 prévue 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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 17, 2019	2019_598570_0009	018921-17, 021418-17, 021861-17, 027475-17	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)

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): March 26, 27, 28, April 2, 3, 4, 5, 8, 9, 10, 11, 12 and 15, 2019

The following logs were inspected:
- Log #018921-17, related to an allegation of resident to resident abuse.
- Log #021418-17, related to an allegation of resident to resident abuse.
- Log #021861-17, related to an allegation of staff to resident abuse.
- Log #027475-17, related to a fall incident 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), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Providers, (PCP), residents and family members.

During the course of the inspection, the inspector toured resident's home areas, observed staff to residents interactions and resident to resident interaction, reviewed resident's health records, the licensee's internal investigations and relevant policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 the care set out in the plan of care was provided to the resident as specified in the plan.

Related to Log #021418-17:

A critical incident report (CIR) was submitted to the Director on specified date, for an allegation of abuse involving resident #002 and resident #003. CIR and progress notes reviews indicated on an identified date and time, Personal Care Provider (PCP) #122 witnessed suspected abuse by resident #003 toward resident #002. The CIR review indicated that the incident occurred while resident #003 had specified intervention in place.

Review of progress notes for resident #003 indicated the following:
- On an identified date, a specified intervention was initiated for resident #003 following an incident involving a co-resident.
- On an identified date, staff assigned for resident #003 went on break and staff were to monitor resident #003. Resident #003 was asked to go to specified residents' area. Staff left the specified residents' area, to assist a co-resident leaving resident #003 unsupervised.
- On specified date and time, resident #002 was found in resident #003's room. PCP #122 witnessed resident #003 in an abusive situation involving resident #002 and both residents were separated immediately. Staff resumed a specified intervention for resident #003.

Review of plan of care, for resident #003 indicated that a specified intervention for responsive behaviour was re-started on a specified date and was updated to twenty four hours a day.

PCP #122 and RPN #123 were not available for interview.

Interview with the Director of Care (DOC), indicated to Inspector #570 that at the time of the incident, resident #003 had a specified intervention in place for a specified period of time each day. The specified intervention was increased to cover all day following the incident involving resident #002. .

The licensee has failed to ensure that resident #003 received care, as specified in the plan of care specific to a specified intervention . [s. 6. (7)]

Issued on this 28th day of May, 2019

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

Original report signed by the inspector.