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

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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
May 17, 2019	2019_598570_0011	016742-17, 027344-17, 005743-18, 011958-18	Complaint

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 Complaint 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 complaint logs were inspected:
- Log #016742-17, related to responsive behaviours and resident's rights.
- Log #027344-17, related to bed refusal.
- Log #005743-18, related to care concerns.
- Log #011958-18, related to care concerns and medication administration.

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), Housekeeping staff, Personal Care Providers, (PCP), Placement Coordinator of CE LHIN, 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:
Admission and Discharge
Dignity, Choice and Privacy
Falls Prevention
Personal Support Services
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
6 WN(s)
4 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 the plan of care is based on an assessment of the resident and the resident's needs and preferences.

Related to Log #005743-18:

The MOHLTC Action Line received a complaint on identified date. A telephone interview was carried out on identified date, with the complainant, resident #001's Substitute Decision Maker (SDM). The complainant indicated to Inspector #570 that they felt resident #001 was neglected and that the resident was unwell all day and they were not notified. The complainant indicated that they found out that the resident was unwell, when they phoned the resident at identified time and was informed by a PSW staff, that the resident was unwell. The complainant indicated they came to the LTC home on an identified date and time and found the resident unwell. The complainant indicated that the resident was given an identified medication after they asked the nurse to do so and they should have done that earlier.

A review of progress notes for resident #001 indicated on identified date and time, RPN #103 documented that the resident did not feel well and wished to remain in their room. The progress notes documentation did not indicate that a full assessment was completed. The progress notes review did not reveal any documentation during the following shift in that same identified date.

A review of the home's investigation notes, completed on identified date, into the SDM's concerns, concluded that registered nurses were educated regarding assessing residents when they complain of feeling unwell and for staff to notify the family when a

resident was unwell.

During an interview with Inspector #570, Personal Care Provider (PCP) #106 indicated resident #001 was not feeling well on an identified date. The resident had refused to eat and kept saying that they were not feeling well but could not say what was wrong with them. The PCP indicated that they reported the resident's complaint to RPN #103.

During an interview with Inspector #570, PCP #109 indicated that resident #001 was not feeling well on an identified date, during an identified shift. That day, the resident complained that they were feeling nauseated. The PCP indicated that they reported to RPN #110 before an identified meal time that the resident was feeling nauseated.

During an interview with Inspector #570, Registered Practical Nurse (RPN) #103 indicated that resident #001 stayed in their room, as they complained of not feeling well but they could not elaborate on what was wrong. The RPN indicated that for resident #001 to refuse two consecutive meals on the identified date was not the norm for the resident. The RPN indicated that the resident was offered tray service and their temperature was checked because the resident was not feeling well. The RPN indicated that if a resident complained of not feeling well, the SDM would not be notified.

During an interview with Inspector #570, RPN #110 indicated that resident #001 refused to come for an identified meal on an identified date. The RPN indicated that the resident was not feeling well. The RPN further indicated that a family member requested a medication to be given to the resident at an identified time and that RN #105 was notified of the request as there was no doctor's order. The RPN indicated that they assessed the resident and there were no concerns noted. The resident denied having pain in an identified area when asked with the family member present. Upon review of progress notes for resident #001 with RPN #110, the RPN acknowledged they did not document assessing the resident.

On an identified date, the DOC was interviewed and the progress notes were reviewed by Inspector #570. The DOC acknowledged that the progress notes documentation did not indicate that a full set of vitals was done for resident #001 on both shifts on identified date. The DOC further indicated, that they investigated SDM's concerns and concluded that nursing staff are to be re-educated, regarding assessing residents and notifying the family when a resident complains of being unwell.

Staff interviews, record reviews did not indicate any documented evidence that resident

#001 was assessed except for their temperature taken when the resident complained of being unwell, nauseated and refused three consecutive meals. [s. 6. (2)]

2. The licensee had failed to ensure that the resident, the SDM, if any, and the designate of the resident/ SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care.

A review of specified unit's daily record of an identified date, indicated resident #001complained of nausea, left the dining room and refused an intervention.

A review of progress notes for resident #001 indicated on an identified date, RPN #103 documented that the resident did not feel well and wished to remain in their room. The progress notes documentation did not indicate a full assessment was completed and weather the resident ate their meals or not.

A review of the point of care (POC) documentation during an identified period of two weeks indicated, that the resident refused three consecutive meals on identified day.

The progress notes review did not indicate that the SDM for resident #001 was notified that the resident was not feeling well and refused three meals.

A review of the home's investigation notes, completed on identified date, into the SDM's concerns, concluded that registered nurses were educated regarding assessing residents when they complain of feeling unwell and for staff to notify the family when a resident was unwell.

During an interview with Inspector #570, Personal Care Provider (PCP) #106 indicated that resident #001 was not feeling well on an identified date. The resident refused to eat and kept saying that they were not feeling good but could not say what was wrong with them. The PCP indicated that they reported that to RPN #103. The PCP further indicated that refusing two consecutive meals was out of character for the resident.

During an interview with Inspector #570, PCP #109 indicated that resident #001 was not feeling well on an identified date, during an identified shift. That day, the resident complained that they were feeling nauseated. The resident was not feeling well the entire day and that the resident stayed in their room which was not the resident's normal behaviour. The PCP indicated that they reported to RPN #110 before an identified meal time that the resident was feeling nauseated.

During an interview with Inspector #570, RPN #103 indicated that resident #001 stayed in their room, as they complained of not feeling well but they could not elaborate on what was wrong. The RPN indicated that for resident #001 to refuse two consecutive meals on identified date was not the norm for the resident. The RPN indicated that the resident was assessed because the resident was not feeling well. The RPN indicated that if a resident complained of not feeling well, SDM would not be notified for that.

During an interview with Inspector #570, RPN #110 confirmed working an identified shift on an identified date. RPN #110 indicated that resident #001 refused to come for an identified meal and was not feeling well. The RPN further indicated that a family member requested a medication to be given to the resident at an identified time and that RN #105 was notified of the request, as there was no doctor's order. The RPN further indicated that they were not aware the resident refused all meals that day and that the resident's SDM should have been notified that the resident refused all meals on an identified date.

On an identified date, during an interview with Inspector #570, the DOC indicated that SDM would be notified if the resident was nauseous and placed on precautions or when there is a change in condition. The DOC further indicated, that the progress notes documentation for resident #001 did not indicate that the resident was placed on precautions and had a change in condition.

The record reviews and staff interviews indicated resident #001's SDM became aware of resident #001 not feeling well when they spoke to the resident and that the SDM was not notified when the resident complained of being nauseated and refused three consecutive meals all day on an identified date. Furthermore, an identified medication was not given to the resident until requested by the resident's SDM. [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 the plan of care is based on an assessment of the resident and the resident's needs and preferences; and to ensure the resident, the SDM, if any, and the designate of the resident/ SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care, 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 has failed to ensure that where the Regulation required the licensee of a long-term care home to have, institute or otherwise put any policy and procedure in place, was complied with.

In accordance with O. Reg. 79/10 s.114 (3) (a), the licensee was required to ensure that written policies related to the medication management system, must be, developed, implemented, evaluated and updated in accordance with evidence- based practices and, if there are none, in accordance with prevailing practices.

The licensee's policy titled Medication Administration, LTC-CA-WQ-200-06-01. The policy, under the procedures section, directs that registered staff will "return to the medication cart and sign for the administration of each medication given before

proceeding to the next resident. Where medications are refused or held, use appropriate numbered code on MAR sheet and chart on progress notes"

Review of Medication Administration Records (MARs) for resident #010 for an identified period, by Inspector #570, related to care concerns brought forward by resident #010's family member revealed four identified medications that were not signed as administered on identified dates, on the resident's MARs.

During an interview with Inspector #570, registered practical nurse (RPN) #124 confirmed that they worked on identified four dates. The RPN indicated that they administered the medication to resident #010 but they did not sign off on the MARs as administered. The RPN acknowledged that the MARs should have been signed after the medications were administered.

During an interview with Inspector #570, the DOC indicated that registered staff should document medications and treatment administered on MARs as per policy and that there should be no unsigned medications noted on the MARs. The DOC confirmed that registered staff did not comply with the above noted Medication Administration policy.

The licensee's Medication Administration policy was not complied with when registered staff did not sign off on MARs after medications were administered to resident #010 on identified dates. [s. 8. (1) (b)]

2. Related to Log #005743-18:

A review of clinical records for resident #001 related to care concerns brought forward by resident #001's family member revealed that an order to administer an identified medication for resident #001 was received at an identified date and time.

A review of the Medication Administration Record (MAR) for an identified period for resident #001 did not indicate that an identified medication was given after it was ordered to the resident on an identified date.

During an interview with Inspector #570, RPN #110 indicated that a family member requested an identified medication to be given to the resident at an identified date and time, and that RN #105 was notified of the request as there was no doctor's order. The RPN indicated that resident was given the identified medication after the order was received but did not recall, if it was them or RN #105 who gave the medication to the

resident. Upon review MARs of an identified period for resident #001 with RPN #110, the RPN acknowledged that there was no documentation that the medication was administered and who gave the medication to the resident and that it should had been signed on the MARs.

During an interview with Inspector #570, RN #105 indicated that RPN #110 gave the resident an identified medication after the order was received. The RN acknowledged that the medication was not signed off as given in MARs and that the MARs should have been signed.

During an interview with Inspector #570, the DOC indicated that RPN #110 did not document on the medication order in the progress notes. The DOC further indicated if the medication was given it should be documented in the MARs. The DOC acknowledged the MARs documentation did not indicate that the identified medication was given.

The licensee's Medication Administration policy was not complied with when registered staff did not sign off on MARs after an identified medication was administered to resident #001 on identified date. [s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put into place is in compliance with and is implemented in accordance with all applicable requirements under the Act, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The Ministry of Health and Long-Term Care (MOHLTC) Action Line had received complaint log #011958-18, on identified date, related to concerns regarding plan of care and medication administration for resident #008.

A telephone interview was conducted by Inspector #570 with the complainant, resident #008's SDM on identified date. The complainant indicated they were concerned about the level of care resident #008 received at this LTC home. The complainant also voiced concerns regarding falls and staff were not doing what they were supposed to do for falls prevention.

Inspector #570 reviewed resident #008's written plan of care. The plan of care indicated the resident was admitted to the LTC home with multiple diagnoses including cognitive decline and conditions that affect mobility. The plan of care review indicated, that the resident was at high risk for falls and required the use of a specified equipment as an intervention for falls prevention.

Review of progress notes by Inspector #570, for an identified period, for resident #008 indicated the resident sustained a fall on an identified date and time. The specified equipment was found not to be working at the time of the fall. The progress notes documentation indicated that the specified equipment was not working all day and that ADOC #119 and Nurse Manager RN #130 were aware.

During an interview with Inspector #570, RPN #125 indicated that resident #008 was

found on the floor on identified date and time. The RPN indicated the specified equipment for falls prevention was not working when it was checked after the resident had fallen.

During an interview with Inspector #570, the ADOC #119 indicated an audit of specified equipment for falls prevention was completed in an identified month and based on that audit more equipment was ordered.

During an interview with Inspector #570, the DOC indicated that all staff are responsible to check the specified equipment for falls prevention to ensure that it is in working order. The DOC indicated that the staff would monitor residents frequently when their specified equipment was not working but this resident was already being monitored frequently. The DOC further indicated that resident #008 should have a specified equipment for falls prevention that is working.

The licensee failed to ensure that a specified equipment for falls prevention used by resident #008 was kept in a good state of repair. [s. 15. (2) (c)]

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 home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Review of clinical records for resident #010 related to care concerns brought forward by resident #010's family member revealed that a specified medication to be applied two times a day, was prescribed on specified date. This medication was not as administered as scheduled at specified time on a number of specified dates.

During an interview with Inspector #570, registered practical nurse (RPN) #124 confirmed that they worked on five specified dates. The RPN further indicated that they did not apply specified medication for resident #010 scheduled at specified time as indicated on the Treatment Administration Record (TAR) for resident#010. The RPN indicated they were not aware of the medication order.

The licensee did not ensure that resident #010 received specified medication in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

2. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

The Ministry of Health and Long-Term Care (MOHLTC) Action Line had received complaint log #011958-18, on identified date, related to concerns regarding plan of care and Medication Administration for resident #008.

A telephone interview with the complainant, resident #008's Substitute Decision-Maker (SDM) on identified date, indicated they were concerned about the level of care resident #008 received at this LTC home. The complainant indicated that a family member was visiting resident #008 and found medications in resident #008's room. The complainant voiced concerns that the resident was not taking prescribed medications.

Review of progress notes for resident #008 identified two incidents of medication found in the resident's room.

During an interview with Inspector #570, housekeeping staff #118 indicated that they found unidentified medication under the bed in resident #008's room about two weeks prior. The housekeeping staff further indicated, that they used to find pills in resident #008's room once or twice a week and that the pills found were given to RPN #125 and recently to the DOC.

On identified date and time, housekeeping staff #118 approached Inspector #570 and indicated that they found a medication on the floor by resident #008's left side of bed at an identified time. The housekeeping staff showed the inspector the pill found and indicated they will give the pill to the DOC.

During an interview with Inspector #570, RPN #118 indicated that resident #008 received medication pass at identified time. The RPN confirmed that the pill found in resident #008's room was one of the resident's prescribed medications.

During an interview with Inspector #570, the DOC indicated that resident #008 can be resistive and pocket the medication. Therefore registered staff were directed to watch the resident swallow the medication. The DOC further indicated that registered staff should ensure that resident swallow their medication and that when a medication is found in resident's room and that medication was determined to be prescribed for that resident indicate that the medication was not given as prescribed.

The licensee did not ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

3. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

On identified date and time, housekeeping staff #118 approached Inspector #570 and indicated that they found a medication in resident #12's room at identified time and the pill was given to the ADOC #121.

During an interview with Inspector #570, RPN #125 indicated that resident #012 received the medication pass. The RPN confirmed that the pill found in resident #12's room was the same prescribed medication for the resident.

During an interview with Inspector #570, the DOC indicated that registered staff should ensure that resident swallow their medication and that when medication is found in resident's room and that medication was determined to be prescribed for that resident indicate that the medication was not given as prescribed.

The licensee did not ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

The Ministry of Health and Long-Term Care (MOHLTC) Action Line had received complaint log #011958-18, on identified date, related to concerns regarding plan of care and Medication Administration for resident #008.

A telephone interview with the complainant, resident #008's Substitute Decision-Maker (SDM) on identified date, indicated to Inspector #570, they were concerned about the level of care resident #008 received at this LTC home. The complainant indicated that a family member was visiting resident #008 and noted a PCP staff signing off for an identified intervention for falls prevention before the time had passed. The complainant further indicated, that PCP staff would sign off the sheets when they have not checked on the resident. The complainant was also concerned regarding falls and that staff were not doing what they were supposed to do for falls prevention.

Inspector #570 reviewed resident #008's written plan of care. The plan of care indicated the resident was admitted to the LTC home with multiple diagnoses including cognitive decline and conditions that affect mobility. The plan of care review indicated, that the resident was at high risk for falls. The plan of care, under falls focus, directed staff to follow a specified intervention for falls prevention.

A review of progress notes by Inspector #570, for specified period, for resident #008 indicated a progress note entry by RPN #125 on specified date and time. RPN #125 documented that at specified time resident was found sitting on the floor. The specified intervention was not signed as completed prior to the fall.

A review of the specified intervention check sheets indicated staff did not sign off that the specified intervention was completed on a number of specified entries during an identified period.

Separate interviews were carried out, with PCPs #119, #120, #125 and #127. The PCPs indicated that resident #008 was at identified risk for falls and that an identified intervention was in place for safety. The PCPs indicated they signed off that the specified interventions was completed.

Interview was carried out with Registered Practical Nurse (RPN) #126. The RPN indicated that resident #008 had frequent falls and had a specified intervention due to identified risk for falls. The RPN further indicated that PCP staff are expected to sign off when the specified intervention was completed. The RPN further indicated, that when the sheet was not signed off that means the specified intervention was not done.

Interview was carried out, with DOC. The DOC indicated that resident #008's family were concerned about the resident falling. Interventions were put in place including a specified intervention. The DOC confirmed that the specified intervention was an intervention to prevent falls and that staff are expected to make sure the resident was safe and sign off the check sheet as it is in the resident's plan of care. Upon review of the check sheets with the DOC, the DOC indicated that the blanks on the check sheets could be that the resident either not monitored or staff did not document that they checked on the resident.

The licensee did not ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented. [s. 30. (2)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the applicant's admission to the home was approved, unless the home lacked the physical facilities necessary to meet the applicant's care requirements, the staff of the home lacked the nursing expertise necessary to meet the applicant's care requirements, or circumstances existed which were provided for in the regulations as being a ground for withholding approval.

On specified date, the Director of Care (DOC) sent a rejection letter to the Placement Coordinator of the Central East Local Health Integration Network (CE LHIN) stating that the home could not approve applicant #011's admission as the home did not have the necessary resources to meet the applicant's needs.

A review of the letter of rejection from Chartwell Wynfield, to applicant #011 identified that the home withheld the approval of Applicant #011's application for admission to a long-term care bed. The letter stated "our staff lacks the nursing expertise necessary to meet the applicant's care requirements". It further stated, "the home cannot provide the care you need because at the present time the applicant's care needs would be more than the home would be able to effectively manage". The letter further stated that "the basis of this

decision includes identified behaviours with no effective management interventions. These behaviours put you and other residents at significant risk".

During a telephone interview the Placement Coordinator from CE LHIN, indicated to Inspector #570 that the Long-Term Care Home (LTCH) initially accepted the applicant's application on specified date with known behaviours. The applicant was matched to bed at the LTCH on specified date and updated information was sent to the LTCH. The application was rejected by the LTCH although they had a Behavioural Supports Ontario (BSO) program at the home and there was no change in the applicant's behavioural assessment from previous assessment when the applicant was initially accepted.

During an interview with Inspector #570, the DOC acknowledged that the LTC home had a BSO program in place to assist the front line staff in how to effectively manage residents with responsive behaviors. The DOC indicated that a large proportion of staff were trained in GPA (gentle persuasion approach). The DOC further indicated, that the application was refused as the applicant was not stable and was at risk to themselves and others. The DOC further indicated, that the information received in the updated application reflected that the applicant would be at risk to themselves and others in long-term care environment due to identified behaviours. The DOC indicated, that although the LTCH had a BSO program, they did not have enough staffing to have one to one assigned for residents with these types of behaviours.

The Placement Coordinator from CE LHIN provided Inspector #570 with copies of the applicant's behavioural assessment tools both the initial and updated assessments that were sent to the LTCH. Both initial and updated behavioural assessment tools identified the applicant's responsive behaviours, triggers and interventions.

The licensee did not provide any documented evidence to support how the home lacked the nursing expertise and necessary resources to meet the applicant's care requirements, or how the applicant's care requirements were outside of the nursing expertise offered in the home although the LTCH had a BSO program and a large proportion of staff at the home were trained in GPA. [s.44. (7) (b)]

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*

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.