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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Amended Public Copy/Copie modifiée 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
Aug 11, 2021	2021_715672_0025 (A1)	004368-21, 005976-21, 005977-21, 006053-21, 007418-21, 007420-21, 008488-21	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 Wynfield Long Term Care Residence
451 Woodmount Drive Oshawa ON L1G 8E3

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

Amended by JENNIFER BATTEN (672) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

An amendment of the report was completed as the Licensee requested an extension of the Compliance Due Date to September 17, 2021.

Issued on this 11st day of August, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Amended by JENNIFER BATTEN (672) - (A1)

Amended 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): June 17, 18, 21, 22 and 23, 2021

The following intakes were completed during this inspection:

One intake related to a resident fall which resulted in a fracture and significant change in condition.

Three intakes related to incidents of staff to resident abuse and/or neglect.

One intake related to improper/incompetent treatment of a resident which resulted in risk of harm to the resident.

Two intakes related to following up on previous Compliance Orders issued to the home regarding staff usage of equipment to assist residents according to the manufacturer's instructions and infection prevention and control practices occurring in the home.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Associate Directors of Care, RAI Coordinator, Behavioural Support Ontario Lead (BSO RPN), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Providers (PCPs), Physiotherapists (PT) and physio assistants (PTA), Housekeepers and residents.

The inspector(s) reviewed clinical health records of identified residents, internal

policies related to Infection Prevention and Control, Falls Prevention, Prevention of Abuse and Neglect, Pain Management, Safe Lifting and Transfers, Restraints, Responsive Behaviours, Skin and Wound Care, Extreme Heat and Cold Weather Precautions. The Inspector(s) also observed staff to resident and resident to resident care and interactions and infection control practices in the home.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home
Skin and Wound Care

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

- **8 WN(s)**
- **5 VPC(s)**
- **3 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
O.Reg 79/10 s. 23.	CO #001	2021_643111_0006	672

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee has failed to ensure that residents in the home were protected from incidents of abuse and/or neglect.

For the purposes of the Act and Regulation, “Neglect” is defined as:

“the failure to provide a resident with the treatment, care, services or assistance

required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.” O. Reg. 79/10.

“Physical Abuse” is defined as:

“the use of physical force by anyone other than a resident that causes physical injury or pain” O. Reg. 79/10.

“Verbal Abuse” is defined as:

“any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident.” O. Reg. 79/10.

A Critical Incident Report was submitted to the Director related to an allegation of staff to resident neglect involving resident #016 and PSW #127. The CIR indicated PSW #127 left resident #016 unattended in the bathtub while collecting supplies, which placed the resident at risk. Three Critical Incident Reports were submitted to the Director related to three allegations of staff to resident abuse involving residents #008, #009, #010 and PSWs #115 and #120. One CIR alleged PSW #120 physically abused resident #009 when they were 'rough' while transferring the resident using a mechanical lift, which left an injury to the resident. Another CIR indicated PSW #115 physically abused resident #008 when they 'pulled hard' on the resident's arm and yelled at the resident. The third CIR indicated PSW #115 neglected and verbally abused resident #010 after the resident had been incontinent of stool and PSW #115 loudly swore and stated in front of the resident and PSW #116 that they refused to clean the resident. Record review of the internal investigation notes indicated each incident had been investigated and PSWs #115, #120 and #127 had each received further education on the prevention of resident abuse and neglect.

During an interview, the Administrator indicated every staff member working in the home received education related to the internal policies regarding the prevention of resident abuse and neglect along with responsive behaviours prior to working with the residents. The Administrator further indicated the home had a zero tolerance policy for resident abuse and neglect, therefore the expectation in the home was for staff to always comply with the internal policies specific to treatment

of the residents, which was why PSWs #115, #120 and #127 had each received further education on the prevention of resident abuse and neglect.

By not ensuring every resident in the home was protected from incidents of abuse and/or neglect residents #008, #009, #010 and #016 were exposed to possible physical and emotional injuries and/or not having their physical needs met through neglect.

Sources: Critical Incident Reports, internal policies related to the prevention of resident abuse and neglect, internal investigation notes for each of the incidents, internal memo(s) related to abuse/neglect, residents #008, #009, #010 and #016's progress notes and written plans of care, interviews with PSWs #115, #120 and the Administrator. [s. 19. (1)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee has failed to ensure residents #009, #013 and #014, who were exhibiting altered skin integrity, were reassessed at least weekly by a member of the registered nursing staff.

A Critical Incident Report was submitted to the Director regarding an incident involving resident #009 and PSW #120. The resident was noted to have a specified number of skin abrasions following the incident. Record review indicated a skin assessment was not completed until an identified number of days following the incident and review of resident #009's health care record until a specified date indicated no further skin assessments had been completed.

Review of the internal policies related to the skin care program indicated that residents with altered skin integrity and current wound care would have their pain assessed with weekly wound care reassessment and the appropriate assessment would be initiated when there was an alteration in a resident's skin integrity. This record was to be completed weekly by Registered Staff and is used to document specific information regarding areas of alteration as well as the treatment and healing of the affected areas.

Resident #013 was noted to have multiple areas of altered skin integrity which they were receiving routine wound care treatment and dressing changes to heal.

Review of the weekly skin assessments completed between an identified period of time indicated there were a specified number of incidents when the assessments were not completed weekly, and some of the assessments did not include measurements of each of the resident's open areas.

Resident #014 was noted to have multiple areas of altered skin integrity which they were receiving routine wound care treatment and dressing changes to heal. Review of the weekly skin assessments completed between an identified period of time indicated there were a specified number of incidents when the assessments were not completed weekly, and some of the assessments did not include measurements of each of the resident's open areas.

During separate interviews, RPNs #110 and #111, ADOC1 and the Administrator indicated the expectation in the home was for skin assessments to be completed on a weekly basis for each area of altered skin integrity. The Administrator further indicated the expectation in the home was for an assessment and documentation in the resident's progress notes to be completed when an area of altered skin integrity was noted to have healed fully.

By not ensuring skin assessments were completed on a weekly basis, as required, residents were placed at risk of having the condition of each area of altered skin integrity worsen. Worsening areas of altered skin integrity could lead to a decline in the resident's overall health status and/or an increase in their level of pain.

Sources: Weekly skin assessments completed for residents #009 and #013 and weekly skin and/or diabetic foot ulcer assessments completed for resident #014; residents #009, #013 and #014's written plans of care; residents #009, #013 and #014's eTARs; interviews with RPNs #110 and #111, ADOC1 and the Administrator. [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

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 :

Compliance Order (CO) #002 related to O. Reg. 79/10, s. 229 (4) from Inspection 2021_643111_0006 issued on April 30, 2021, with a compliance due date of May 31, 2021, is being re-issued as follows:

The licensee has failed to ensure that the staff followed the home's infection prevention and control (IPAC) practices.

A follow-up inspection was conducted, and the staff continued to be noncompliant with the implementation of the home's IPAC program.

During observations conducted in the home, Inspector observed the following:

- No hand hygiene was offered/performed on residents prior to or following food and/or fluid intake during meals or nourishment services.

- Staff were not observed completing hand hygiene between assisting/serving residents during meals and nourishment services.

- There was signage posted in the home for only three individuals to ride an elevator at a time, but there were instances when more than three staff members were observed in an elevator cart.

- Resident #002 was noted to receive an identified procedure nightly, but there was no signage posted to indicate the required precautions when the procedure was in use.

- Administrator indicated the home did not have an internal policy related to masking of residents, as directed on page six of Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007.

- Three staff members were observed to be sitting in an office together while not maintaining physical distancing or wearing the required facial masks.

- Staff were observed on a resident home area to be having a social gathering of what appeared to be a baby shower for another staff member, while not maintaining physical distancing and not wearing the required PPE items, such as masks and/or face shields/goggles.

- Residents were observed to be seated in television lounges without maintaining physical distancing.

- Housekeeping and PSW staff members were observed to be walking in the hallways with gloves on.

The observations demonstrated that that there were inconsistent IPAC practices from the staff and essential caregivers of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents, including the possibility of the COVID-19 virus.

Sources: Observations conducted; Directive #3 for Long-Term Care Homes; interviews with PSWs, RPNs, RNs, maintenance and housekeeping staff, Associate Directors of Care, Director of Care and Administrator. [s. 229. (4)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 003

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

Three Critical Incident Reports were submitted to the Director related to three allegations of staff to resident abuse involving residents #008, #009, #010 and PSWs #115 and #120. Review of the CIR indicated on the date of the incident RPN #121 approached resident #009 with their medications and the resident reported the incident involving PSW #120, and RPN #121 followed up with the PSW regarding the concerns brought forward. The CIR further indicated the Director was not notified via the after-hours pager. During separate interviews, the Administrator indicated they were not immediately notified of the incident, as RPN #121 had informed the management team of the allegation via an email. RPN #121 verified they had received previous education related to the notification requirements prior to the incident involving resident #009 and PSW #120. Review of two of the CIRs indicated the dates the incidents occurred on and the Director was not notified via the after-hours pager. During separate interviews, the Administrator indicated they were notified of the incidents via an email sent by PSW #116. The Administrator further indicated every staff member working in the home had received education related to the internal policies regarding the prevention of resident abuse and neglect, which included the requirement of every allegation to be immediately reported. PSW #116 verified they had received previous education related to the notification requirements prior to the incidents involving residents #008, #010 and PSW #115.

By not ensuring every allegation of resident abuse or neglect was immediately reported, residents were placed at risk of being exposed to further incidents, due to the accused staff members continuing to work on the resident home areas.

Sources: Four identified Critical Incident Reports, internal policies related to the prevention of resident abuse and neglect, internal investigation notes for each of the incidents, internal memo(s) related to abuse/neglect, interviews with PSWs #115, #116, #120, RPN #121 and the Administrator. [s. 20. (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 written policies which promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

The licensee has failed to ensure that temperatures required to be measured under subsection (2) were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Review of the internal 'Indoor Air Temperature and Humidex Monitoring Record' indicated the licensee was monitoring air temperatures twice daily, instead of the required three times per day. During separate interviews, maintenance worker #107 and the Administrator verified temperatures in the home were only being measured and documented twice per day.

By not ensuring temperatures were measured at a minimum of three times per day, as per the requirement, residents were placed at possible risk of being exposed to rooms with elevated temperatures, which could lead to discomfort and dehydration.

Sources: Internal 'Indoor Air Temperature and Humidex Monitoring Record' forms, interviews with maintenance worker #107 and the Administrator. [s. 21. (3)]

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 temperatures required to be measured under subsection (2) were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night, to be implemented voluntarily.

WN #6: 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 :

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #005.

A Critical Incident Report was submitted to the Director related to an incident which occurred related to the improper/incompetent treatment of a resident that resulted in harm or risk to the resident, which involved resident #005 and PSWs #117 and #118. The CIR indicated that resident #005 sustained a fall and PSW #118 admitted to picking the resident up off the floor from behind "bear hug" style and pulling the resident from one room to the next. Review of resident #005's written plan of care in place at the time of the incident indicated the resident had an identified weight bearing status and required a specified level of assistance from an identified number of staff members for all transfers. During separate interviews, PSW #118 verified the information from the Critical Incident Report and indicated they had received prior education and training related to the internal safe lift and transfer policy. The Administrator indicated the expectation in the home was for all staff to adhere to the internal safe lift and transfer policy, which directed there were no resident manual lifts permitted in the home and follow each resident's individualized plan of care.

By not ensuring PSW #118 adhered to the internal safe lift and transfer policy and follow resident #005's plan of care, the resident was placed at risk of sustaining another fall if dropped by PSW #118 and/or an injury due to the improper transfer.

Sources: Resident #005's written plan of care; internal policy related to the safe transfer program; internal investigation notes and interviews with PSWs #117, #118 and the Administrator. [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 to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

The licensee failed to ensure that personal items were labelled, as required.

Observations conducted in the home revealed there were multiple personal items in shared resident bathrooms, tub rooms and shower rooms, such as used rolls of deodorant, hair combs and hairbrushes, nail clippers and razors which were not labelled with the resident's name. Several observations in shared resident bathrooms, tub rooms and shower rooms during the identified dates indicated there were unlabelled personal items being used for the residents, but staff members could not indicate who the items belonged to and/or were used for residents if the staff had forgotten to bring the resident's own personal item to the shower room.

During separate interviews, the DOC verified the expectation in the home was for all personal items to be labelled with the resident’s name. By not ensuring all personal items were labelled, residents were placed at risk of using another resident’s personal item, which could be unsanitary.

Sources: Observations conducted in the home, interviews with PSWs, RPNs, DOC and the Administrator. [s. 37. (1) (a)]

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 o ensure that personal items are labelled, as required, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

The licensee has failed to ensure that proper techniques including safe positioning, were used to assist resident #012, who required assistance with eating.

During observations conducted in the home, resident #012 was served a meal and was attempting to eat with the assistance of PSW #124, while seated in a tilted position. Resident #012 was noted to begin coughing significantly, to the point that the resident had to be assisted out of the dining room by staff. PSW #124 indicated resident #012 always received their food/fluid intake while seated in a tilted position due to an identified reason. Review of resident #012's current written plan of care did not support the information provided by PSW #124.

During separate interviews, RPNs #110, #121, ADOC1 and the Administrator indicated the expectation in the home was for all residents to be seated in a safe position during food and fluid intake.

Sources: Observations conducted in the home and interviews with RPNs #110, #121, ADOC1 and the Administrator. [s. 73. (1) 10.]

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 proper techniques including safe positioning, are used to assist residents who require assistance with eating, to be implemented voluntarily.

Issued on this 11st day of August, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JENNIFER BATTEN (672) - (A1)
Inspection No. / No de l'inspection :	2021_715672_0025 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	004368-21, 005976-21, 005977-21, 006053-21, 007418-21, 007420-21, 008488-21 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 11, 2021(A1)
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 Wynfield Long Term Care Residence 451 Woodmount Drive, Oshawa, ON, L1G-8E3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Debbie Mccance

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

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:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with section s. 19 (1) of O. Reg 79/10 of the LTCHA.

Specifically, the licensee must:

1. Educate PSWs #115, #116, #120 and #127 on the internal policy entitled "Abuse Free Communities - Prevention, Education and Analysis", policy number: LTC-CA-WQ-100-05-18; Effective Date: July 2010; Last Revised: July 2016 and responsive behaviours policy. Test the PSW's knowledge and keep a documented record of the process.

2. Educate all nursing staff (PSWs, RPNs, RNs) on the internal policy entitled "Abuse Free Communities - Prevention, Education and Analysis", policy number: LTC-CA-WQ-100-05-18; Effective Date: July 2010; Last Revised: July 2016 specific to the reporting requirements and appropriate ways to contact/notify the required individuals of any allegation/incident of resident abuse and/or neglect. Test the staff member's knowledge related to the reporting requirements and keep a documented record of the process.

Grounds / Motifs :

(A1)
1. The licensee has failed to ensure that residents in the home were protected from incidents of abuse and/or neglect.

For the purposes of the Act and Regulation, "Neglect" is defined as:

"the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents." O. Reg. 79/10.

"Physical Abuse" is defined as:

"the use of physical force by anyone other than a resident that causes physical injury or pain" O. Reg. 79/10.

"Verbal Abuse" is defined as:

"any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident." O. Reg. 79/10.

A Critical Incident Report was submitted to the Director related to an allegation of staff to resident neglect involving resident #016 and PSW #127. The CIR indicated PSW #127 left resident #016 unattended in the bathtub while collecting supplies, which placed the resident at risk. Three Critical Incident Reports were submitted to the Director related to three allegations of staff to resident abuse involving residents #008, #009, #010 and PSWs #115 and #120. One CIR alleged PSW #120 physically abused resident #009 when they were 'rough' while transferring the resident using a mechanical lift, which left an injury to the resident. Another CIR indicated PSW #115 physically abused resident #008 when they 'pulled hard' on the resident's arm and yelled at the resident. The third CIR indicated PSW #115 neglected and verbally abused resident #010 after the resident had been incontinent of stool and PSW #115 loudly swore and stated in front of the resident and PSW #116 that they refused to clean the resident. Record review of the internal investigation notes indicated each incident had been investigated and PSWs #115, #120 and #127 had each received further education on the prevention of resident abuse and neglect.

During an interview, the Administrator indicated every staff member working in the home received education related to the internal policies regarding the prevention of resident abuse and neglect along with responsive behaviours prior to working with

the residents. The Administrator further indicated the home had a zero tolerance policy for resident abuse and neglect, therefore the expectation in the home was for staff to always comply with the internal policies specific to treatment of the residents, which was why PSWs #115, #120 and #127 had each received further education on the prevention of resident abuse and neglect.

By not ensuring every resident in the home was protected from incidents of abuse and/or neglect residents #008, #009, #010 and #016 were exposed to possible physical and emotional injuries and/or not having their physical needs met through neglect.

Sources: Critical Incident Reports, internal policies related to the prevention of resident abuse and neglect, internal investigation notes for each of the incidents, internal memo(s) related to abuse/neglect, residents #008, #009, #010 and #016's progress notes and written plans of care, interviews with PSWs #115, #120 and the Administrator.

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

Severity: There was actual harm and risk of harm to the residents, as multiple residents were subjected to incidents of neglect and abuse.

Scope: The scope of this non-compliance was widespread, as three or more residents were affected.

Compliance History: A Compliance Order was issued to the home during Critical Incident System inspection #2020_715672_0021 which was issued to the home on January 27, 2021, and complied on April 12, 2021.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 17, 2021(A1)

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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: 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must be compliant with section s. 50. (2) (b) (iv) of O.Reg 79/10 of the LTCHA.

Specifically, the licensee must:

1. Educate every member of the Registered nursing staff (RPNs and RNs) on the internal policies entitled "Skin Care Program Overview"; policy number: LTC-CA-WQ-200-08-01; revision date: December 2017, and "Wound Care Treatment"; policy number; LTC-CA-WQ-200-08-03; revision date: December 2017. Keep a documented record of the process.

2 Conduct weekly audits of the skin assessments completed for residents #013 and #014, along with the other residents in the home with pressure ulcers, for a period of six weeks to ensure the assessments are being completed as per the weekly schedule. Keep a documented record of the audits completed and any intervention(s) implemented, if non-compliance is noted.

Grounds / Motifs :

(A1)
1. The licensee has failed to ensure residents #009, #013 and #014, who were exhibiting altered skin integrity, were reassessed at least weekly by a member of the registered nursing staff.

A Critical Incident Report was submitted to the Director regarding an incident involving resident #009 and PSW #120. The resident was noted to have a specified number of skin abrasions following the incident. Record review indicated a skin assessment was not completed until an identified number of days following the incident and review of resident #009's health care record until a specified date indicated no further skin assessments had been completed.

Review of the internal policies related to the skin care program indicated that residents with altered skin integrity and current wound care would have their pain assessed with weekly wound care reassessment and the appropriate assessment would be initiated when there was an alteration in a resident's skin integrity. This record was to be completed weekly by Registered Staff and is used to document specific information regarding areas of alteration as well as the treatment and healing

of the affected areas.

Resident #013 was noted to have multiple areas of altered skin integrity which they were receiving routine wound care treatment and dressing changes to heal. Review of the weekly skin assessments completed between an identified period of time indicated there were a specified number of incidents when the assessments were not completed weekly, and some of the assessments did not include measurements of each of the resident's open areas.

Resident #014 was noted to have multiple areas of altered skin integrity which they were receiving routine wound care treatment and dressing changes to heal. Review of the weekly skin assessments completed between an identified period of time indicated there were a specified number of incidents when the assessments were not completed weekly, and some of the assessments did not include measurements of each of the resident's open areas.

During separate interviews, RPNs #110 and #111, ADOC1 and the Administrator indicated the expectation in the home was for skin assessments to be completed on a weekly basis for each area of altered skin integrity. The Administrator further indicated the expectation in the home was for an assessment and documentation in the resident's progress notes to be completed when an area of altered skin integrity was noted to have healed fully.

By not ensuring skin assessments were completed on a weekly basis, as required, residents were placed at risk of having the condition of each area of altered skin integrity worsen. Worsening areas of altered skin integrity could lead to a decline in the resident's overall health status and/or an increase in their level of pain.

Sources: Weekly skin assessments completed for residents #009 and #013 and weekly skin and/or diabetic foot ulcer assessments completed for resident #014; residents #009, #013 and #014's written plans of care; residents #009, #013 and #014's eTARs; interviews with RPNs #110 and #111, ADOC1 and the Administrator.

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

Severity: There was actual risk of harm to the residents, as residents were placed at risk of having the condition of each area of altered skin integrity worsen.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

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

.
Scope: The scope of this non-compliance was was widespread, as three out of three residents inspected upon were affected.

Compliance History: A Voluntary Plan of Correction was issued to the home during Complaint inspection #2020_694166_0007 which was issued to the home on February 27, 2020.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Sep 17, 2021(A1)

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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: 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2021_643111_0006, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with with s. 229 (4) of O. Reg. 79/10 of the LTCHA.

Specifically, the licensee must:

1. Provide leadership, monitoring, and supervision in all home areas to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices.

2. Provide on the spot education and training to staff not adhering with appropriate IPAC measures and track the results of the audits completed to assess if the same staff members are involved in areas of non-compliance. Keep a documented record of the process completed.

Grounds / Motifs :

(A1)
1. Compliance Order (CO) #002 related to O. Reg. 79/10, s. 229 (4) from Inspection 2021_643111_0006 issued on April 30, 2021, with a compliance due date of May 31, 2021, is being re-issued as follows:

The licensee has failed to ensure that the staff followed the home's infection prevention and control (IPAC) practices.

A follow-up inspection was conducted, and the staff continued to be noncompliant

with the implementation of the home's IPAC program.

During observations conducted in the home, Inspector observed the following:

- No hand hygiene was offered/performed on residents prior to or following food and/or fluid intake during meals or nourishment services.

- Staff were not observed completing hand hygiene between assisting/serving residents during meals and nourishment services.

- There was signage posted in the home for only three individuals to ride an elevator at a time, but there were instances when more than three staff members were observed in an elevator cart.

- Resident #002 was noted to receive an identified procedure nightly, but there was no signage posted to indicate the required precautions when the procedure was in use.

- Administrator indicated the home did not have an internal policy related to masking of residents, as directed on page six of Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007.

- Three staff members were observed to be sitting in an office together while not maintaining physical distancing or wearing the required facial masks.

- Staff were observed on a resident home area to be having a social gathering of what appeared to be a baby shower for another staff member, while not maintaining physical distancing and not wearing the required PPE items, such as masks and/or face shields/goggles.

- Residents were observed to be seated in television lounges without maintaining physical distancing.

- Housekeeping and PSW staff members were observed to be walking in the hallways with gloves on.

The observations demonstrated that that there were inconsistent IPAC practices from

the staff and essential caregivers of the home. There was actual risk of harm to residents associated with these observations. By not adhering to the home's IPAC program, there could be possible transmission of infectious agents, including the possibility of the COVID-19 virus.

Sources: Observations conducted; Directive #3 for Long-Term Care Homes; interviews with PSWs, RPNs, RNs, maintenance and housekeeping staff, Associate Directors of Care, Director of Care and Administrator.

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

Severity: There was actual risk of harm to the residents because of the potential for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program.

Scope: The scope of this non-compliance was widespread, as the IPAC related concerns were identified during observations throughout the home, and the areas of non-compliance has the potential to affect a large number of the LTCH's residents.

Compliance History: A Compliance Order was issued to the home during Critical Incident System inspection #2021_643111_0006 which was issued to the home on April 30, 2021, with a compliance due date of May 31, 2021. (672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 17, 2021(A1)

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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.

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

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

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 revision 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 11st day of August, 2021 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by JENNIFER BATTEN (672) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Service Area Office / Bureau régional de services : Central East Service Area Office