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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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
Dec 22, 2021	2021_673672_0037 (A1)	012648-21, 012649-21, 014081-21, 015997-21, 016551-21	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 FRANK GONG (694426) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Upon request from the Licensee, this compliance due date has been extended to January 31, 2022.

Issued on this 22nd day of December, 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*

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
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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
Dec 22, 2021	2021_673672_0037 (A1)	012648-21, 012649-21, 014081-21, 015997-21, 016551-21	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 FRANK GONG (694426) - (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): October 19-22, 28, 29, November 1-5, 8-10, 12, 16, 17, 2021

The following intakes were completed during this critical incident system inspection:

Two intakes related to following up on previous Compliance Orders issued to the licensee during Critical Incident System inspection #2021_715672_0025; issued on July 28, 2021, with a compliance due date of August 18, 2021, which was then extended until September 17, 2021.

One intake related to a resident fall with significant injury and change in condition.

Two intakes related to allegations of staff to resident abuse and/or neglect.

A Complaint inspection (#2021_673672_0036) was conducted concurrently to this Critical Incident System Inspection. Findings specific to falls prevention and infection prevention and control were issued within the Complaint inspection report #2021_673672_0036.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Associate Directors of Care, Corporate Environmental Consultant, Corporate Clinical Consultant, IPAC Lead, Public Health Consultants, 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), Registered Dietitian, Food and Nutrition Manager (FNM) and Assistant Food and Nutrition Manager (AFNM), dietary aides, 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 Food Handling and Serving Temperatures, Responsive Behaviours, Skin and Wound Care. The Inspector(s) also observed staff to resident and resident to resident care and interactions along with infection control practices in the home.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 50. (2)	CO #002	2021_715672_0025	694426

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 :

1. A Compliance Order (CO #001) was issued to the licensee related to O. Reg. 79/10, s. 19 (1) during Inspection #2021_715672_0025, with a compliance due date of August 18, 2021, which was extended until September 17, 2021. The Compliance Order is being re-issued as follows:

The licensee has failed to ensure that resident #003 was protected from 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

Resident #003 had a history of responsive behaviours, and required an identified intervention.

PSW #156 determined that resident #003 had not received required personal care for a period of time. PSW #156 indicated that at the time of the incident, the resident was noted to be exhibiting identified responsive behaviours. According to the DOC, internal camera footage indicated that care was not provided to resident #003 on a specified date during an identified period of time. This was verified by resident #003's assigned staff.

PSW #108 indicated that they did not recall whether they provided personal care to the resident, however they did document that care was provided.

The DOC verified the allegation of neglect to resident #003 was substantiated. The DOC indicated that all nursing staff members had received education related to the internal policy regarding the prevention of resident abuse and neglect.

Failure to ensure resident #003 was protected from neglect may have resulted in physical and/or emotional injuries from unmet needs.

Sources: Related critical incident report; internal investigation notes; resident #003’s plan of care, progress notes and documentation survey report; interviews with PSWs #107, #108, #121, #153, #156, and DOC. [s. 19. (1)]

2. The licensee has failed to ensure that resident #032 was protected from neglect.

Resident #032 was found to require assistance with personal care on a specified date and time and staff indicated that personal care had not been provided during the identified shift. During the course of the internal investigation, PSW #158 and #159 indicated they did not provide care to the resident despite care being

documented as completed by PSW #159.

After discussion with ADOC1, it was noted that the allegation of neglect was founded and the resident endorsed feelings of embarrassment following the incident. ADOC1 indicated that some risks involved with not being provided with timely personal care included skin breakdown and negative effects to residents' mental well-being.

Failure to ensure resident #032 was protected from neglect may have resulted in physical and/or emotional injuries to the resident from unmet needs.

Sources: Related critical incident report; internal investigation notes; resident #032's plan of care, progress notes, and documentation survey report v2; interviews with the resident and ADOC1. [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

Issued on this 22nd day of December, 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 FRANK GONG (694426) - (A1)
Inspection No. / No de l'inspection :	2021_673672_0037 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	012648-21, 012649-21, 014081-21, 015997-21, 016551-21 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 22, 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)

Linked to Existing Order / Lien vers ordre existant: 2021_715672_0025, CO #001;

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 the LTCHA.

Specifically, the licensee must:

1. Educate all PSW staff 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 resident neglect. Education is to include expectations when a resident has refused care. Test the staff member's knowledge and keep a documented record of the process.

2. Educate all PSW staff on the internal policy related to documentation expectations in Point of Care, to ensure staff are only documenting on residents they have provided direct care to. Education is to include expectations when a resident has refused care. Test the staff member's knowledge and keep a documented record of the process.

Grounds / Motifs :

1. A Compliance Order (CO #001) was issued to the licensee related to O. Reg. 79/10, s. 19 (1) during Inspection #2021_715672_0025, with a compliance due date of August 18, 2021, which was extended until September 17, 2021. The Compliance Order is being re-issued as follows:

The licensee has failed to ensure that resident #003 was protected from 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

Resident #003 had a history of responsive behaviours, and required an identified intervention.

PSW #156 determined that resident #003 had not received required personal care for a period of time. PSW #156 indicated that at the time of the incident, the resident was noted to be exhibiting identified responsive behaviours. According to the DOC, internal camera footage indicated that care was not provided to resident #003 on a specified date during an identified period of time. This was verified by resident #003's assigned staff.

PSW #108 indicated that they did not recall whether they provided personal care to the resident, however they did document that care was provided.

The DOC verified the allegation of neglect to resident #003 was substantiated. The DOC indicated that all nursing staff members had received education related to the internal policy regarding the prevention of resident abuse and neglect.

Failure to ensure resident #003 was protected from neglect may have resulted in physical and/or emotional injuries from unmet needs.

Sources: Related critical incident report; internal investigation notes; resident #003's plan of care, progress notes and documentation survey report; interviews with PSWs #107, #108, #121, #153, #156, and DOC. [s. 19. (1)]

2. The licensee has failed to ensure that resident #032 was protected from neglect.

Resident #032 was found to require assistance with personal care on a specified date and time and staff indicated that personal care had not been provided during the

identified shift. During the course of the internal investigation, PSW #158 and #159 indicated they did not provide care to the resident despite care being documented as completed by PSW #159.

After discussion with ADOC1, it was noted that the allegation of neglect was founded and the resident endorsed feelings of embarrassment following the incident. ADOC1 indicated that some risks involved with not being provided with timely personal care included skin breakdown and negative effects to residents' mental well-being.

Failure to ensure resident #032 was protected from neglect may have resulted in physical and/or emotional injuries to the resident from unmet needs.

Sources: Related critical incident report; internal investigation notes; resident #032's plan of care, progress notes, and documentation survey report v2; interviews with the resident and ADOC1.

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

Severity: There was actual risk of harm to the residents due to not having their care needs met.

Scope: The scope of this non-compliance was widespread, as the non-compliance had the potential to affect a large number of the LTCH's residents.

Compliance History: A Compliance Order was issued during Critical Incident System inspection #2021_715672_0025 which was served to the licensee on July 28, 2021, with a compliance due date of August 18, 2021, which was then extended until September 17, 2021. Another Compliance Order was issued during Critical Incident System inspection #2020_715672_0021, and was issued to the licensee on January 27, 2021, which was complied on April 12, 2021.
(694426)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2022(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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 22nd day of December, 2021 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Amended by FRANK GONG (694426) - (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