

**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

Public Copy/Copie 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
Feb 1, 2022	2022_882760_0002	019630-21, 020297-21	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

JACK SHI (760), ELLA LEVINSKAYA (734225)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 11, 12, 13, 2022.

The following intakes were completed in this critical incident inspection:

**A log was related to a fall;
A log was related to an outbreak.**

During the course of the inspection, the inspector(s) spoke with Registered Nurses (RN), Personal Support Workers (PSW), the Assistant Director of Care (ADOC), the Administrator and the Director of Care (DOC).

During the course of the inspection, the inspector toured the home, observed Infection Prevention and Control (IPAC) practices, observed care activities on the units, reviewed relevant policies and procedures and reviewed resident records.

The following Inspection Protocols were used during this inspection:

**Falls Prevention
Infection Prevention and Control**

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

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
- (a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
 - (b) the resident’s care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
 - (c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

Findings/Faits saillants :

1. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan has not been effective.

Resident #001 had sustained a fall. The resident was found by staff and had a change in their condition and an assessment was completed. The resident passed away shortly after this fall. A root cause was identified related to their risk of falls and a falls prevention strategy was developed in their care plan.

During interviews with the DOC, a PSW, and the ADOC/falls lead, they all acknowledged that the resident had a high risk for falls and the fall prevention intervention that was developed in their care plan was ineffective and that different approaches should have been considered in preventing falls for the resident. In particular, the ADOC/falls lead and DOC indicated that specific interventions should have been trialed for the resident, but was not.

The lack of effective falls prevention interventions placed the resident in actual risk for injuries resulting from falls.

Sources: Resident #001 progress notes, resident #001 care plan, Interviews with the DOC, a PSW, and the ADOC/falls lead. (734225) [s. 6. (10) (c)]

Additional Required Actions:

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

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 the falls prevention policies and procedures included in the required Falls Prevention Program were complied with, for resident #001.

In accordance with O.Reg. 79/10, s. 48(1), the licensee was required to ensure that a falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented.

Specifically, the licensee's Resident Falls Prevention Program requires an Environmental Fall Risk Assessment to be completed for each resident on admission to implement fall prevention strategies to modify the environment in order to reduce the risk for falls and injury.

A completed assessment could not be located for residents #001, #002, #003. The ADOC/falls lead confirmed the assessments were not completed for these residents.

This gap in completing the assessments increased the likely that appropriate interventions would not be in place to prevent falls and injury for resident.

Sources: Resident Fall Prevention Program and policy, interview with the ADOC/falls lead. [s. 8. (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 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, is complied with, to be implemented voluntarily.

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 :

1. The licensee failed to ensure staff followed the home's infection prevention and control (IPAC) program.

The home submitted a Critical Incident Systems (CIS) report indicating an outbreak in the home. Multiple residents and staff had tested positive for the virus. As per directions from the local public health unit (PHU), specific units in the home were put into an outbreak and all residents on those units were on contact/droplet precautions. In addition, the PHU directed the staff in the home to wear N95 masks if they are in direct contact with the residents or going into resident rooms on the units with positive cases.

The following observations were made in the home during the inspection:

- Multiple staff members and an essential caregiver who were feeding residents in the common areas of a resident unit, did not wear gowns or gloves. The DOC clarified that as per directions from the PHU, the staff are to wear full personal protective equipment (PPE) including gowns and gloves when they are feeding residents in the common areas of the resident unit.
- A housekeeper was seen coming out of resident room and wore two surgical masks on top of each other. The housekeeper stated they did not need to wear a N95 mask while on their unit. The DOC clarified that all staff are fit tested to wear a N95 mask on this resident unit, as there are positive cases on that floor and therefore the housekeeper should have worn a N95 mask when they entered the resident room.

The failure to adhere to the appropriate IPAC practices in the home may result in further spread of the virus outbreak.

These findings are further evidence to support the order issued on December 22, 2021, during complaints inspection #2021_673672_0036 to be complied January 31, 2022.

Sources: Interviews with the DOC, a housekeeper; Review of the home's CIS report. [s. 229. (4)]

Issued on this 3rd day of February, 2022

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

Original report signed by the inspector.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : JACK SHI (760), ELLA LEVINSKAYA (734225)

Inspection No. /

No de l'inspection : 2022_882760_0002

Log No. /

No de registre : 019630-21, 020297-21

Type of Inspection /

Genre d'inspection: Critical Incident System

Report Date(s) /

Date(s) du Rapport : Feb 1, 2022

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

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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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:

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

- (a) a goal in the plan is met;
- (b) the resident's care needs change or care set out in the plan is no longer necessary; or
- (c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee must comply with LTCHA s. 6 (10) (c)

Specifically, the licensee must:

- Residents at high risk for falls and history of falls are identified
- The interventions identified in the plan of care of residents at high risk for falls and history of falls are reviewed and revised at least every six months and at any other time when the care set out in the plan has not been effective.

Grounds / Motifs :

Order(s) of the Inspector**Ordre(s) de l'inspecteur**

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

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

1. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan has not been effective.

Resident #001 had sustained a fall. The resident was found by staff and had a change in their condition and an assessment was completed. The resident passed away shortly after this fall. A root cause was identified related to their risk of falls and a falls prevention strategy was developed in their care plan.

During interviews with the DOC, a PSW, and the ADOC/falls lead, they all acknowledged that the resident had a high risk for falls and the fall prevention intervention that was developed in their care plan was ineffective and that different approaches should have been considered in preventing falls for the resident. In particular, the ADOC/falls lead and DOC indicated that specific interventions should have been trialed for the resident, but was not.

The lack of effective falls prevention interventions placed the resident in actual risk for injuries resulting from falls.

Sources: Resident #001 progress notes, resident #001 care plan, Interviews with the DOC, a PSW, and the ADOC/falls lead. (734225)

Severity: There was actual harm to the resident, since the resident died shortly after they had sustained their fall.

Scope: The scope of this non-compliance was isolated, as one resident was identified in this non-compliance, out of a scope of three.

Compliance History: In the last 36 months, two Voluntary Plan of Corrections (VPC's) and two Written Notifications (WN's) was issued to the home during a Critical Incident Systems inspection #2019_671684_0039 which was issued to the home on November 18, 2019. (734225) (760)

**This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :**

Mar 31, 2022

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
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2007, chap. 8

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section 154 of the *Long-Term
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2007, c. 8

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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

Ordre(s) de l'inspecteur

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

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.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

**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, 8^e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Order(s) of the Inspector**Ordre(s) de l'inspecteur**

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

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 révision
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 1st day of February, 2022

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : Jack Shi

Service Area Office /

Bureau régional de services : Central East Service Area Office