Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report under the
Fixing Long-Term Care Act, 2021

Central East Service Area Office
33 King Street West, 4th Floor
Oshawa ON L1H 1A1
Telephone: 1-844-231-5702
CentralEastSAO.moh@ontario.ca

Original Public Report

Report Issue Date August 31, 2022
Inspection Number 2022-1370-0001
Inspection Type
☐ Critical Incident System ☐ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Regency LTC Operating Limited Partnership

Long-Term Care Home and City
Chartwell Wynfield Long Term Care Residence, Oshawa

Lead Inspector
Susan Semeredy (501)

Additional Inspector(s)
Maria Paola Pistritto (741736)

Inspector Digital Signature
Susan L Semeredy
Digitally signed by Susan L Semeredy
Date: 2022.09.06 11:29:54 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 18, 19, 22, 23, 24, 2022.

The following intake(s) were inspected:

- Intake # 008276-22 (Follow-up) related to IPAC
- Intake # 008275-22 (Follow-up) related to safe positioning at meals
- Intake # 008274-22 (Follow-up) related to labelling of personal items
- Intake # 008267-22 (Follow-up) related to storage of medication
- Intake # 008266-22 (Follow-up) related to collaboration regarding diagnostic results

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	s.37(1)	2022_673672_0007	001	Susan Semeredy (501)
O. Reg. 79/10	s.73(1)10	2022_673672_0007	002	Susan Semeredy (501)
O. Reg. 79/10	s.229(4)	2022_673672_0007	003	Susan Semeredy (501)
LTCHA, 2007	s.6(4)	2022_673672_0008	001	Maria Paolo Pistritto (741736)
O. Reg. 79/10	s.129(1)	2022_673672_0008	002	Maria Paolo Pistritto (741736)

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The following **Inspection Protocols** were used during this inspection:

- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Medication Management
- Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION [RESPONSIVE BEHAVIOURS]

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s.58. (4) (b)

The licensee has failed to ensure that strategies were developed and implemented to respond to a resident's responsive behaviours when being assisted.

Rationale and Summary

Observations indicated staff had difficulty assisting a resident. PSWs were observed to have inconsistent interventions to manage these behaviours and appeared frustrated. The resident had a history of responsive behaviours and the plan of care did not indicate there were any strategies developed to respond to their responsive behaviours with regard to a specific activity of daily living. The Nursing Consultant confirmed such strategies had not been developed and implemented.

Failing to develop and implement strategies to respond to a resident's responsive behaviours put them and others at risk.

Sources: Observations, review of the resident's health record and interviews with the Nursing Consultant and other staff.
[501]