

**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
Aug 26, 2021	2021_598570_0017	024230-20, 001313-21, 003960-21, 004312-21, 004750-21, 012287-21, 012467-21	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 Woodhaven Long Term Care Residence
380 Church Street Markham ON L6B 1E1

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

SAMI JAROUR (570), SUSAN SEMEREDY (501)

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): August 11, 12, 13, 16, 17, 18, 19, 20, 2021.

The following intakes were inspected in this critical incident inspection:

Log #024230-20, related to a fall incident.

Log #001313-21, related to an injury.

Log #003960-21, related to a fall incident.

Log #004312-21, related to a fall incident.

Log #004750-21, related to a fall incident.

Log #012287-21, related to a fall incident.

Log #012467-21, related to a fall incident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Physiotherapist (PT), Maintenance Supervisor, Unit Clerk, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Providers (PCP), Recreation Aide (RA), and residents.

During the course of the inspection, the inspector (s) observed resident and staff interactions and IPAC practices; reviewed clinical health records, relevant home policies and procedures, the home's investigation notes, Air Temperature and Humidex Monitoring Records, and other pertinent documents.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Infection Prevention and Control

Personal Support Services

Safe and Secure Home

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

2 WN(s)

0 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 O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a specified safety device for resident #010 was readily available for the resident.

Resident #010 sustained a fall that resulted in an injury.

Resident #010's written plan of care directed staff to ensure appropriate safety device was in use.

Personal Care Provider (PCP) #113 indicated that resident #010 did not have their safety device in use as none could be found for the resident prior to the fall incident.

Registered Practical Nurse (RPN) #117 confirmed that the resident did not have the safety device in use when they fell and sustained an injury. RPN #117 indicated that prior to resident #010's fall, ADOC #101 was informed that resident #010 did not have the safety device and that the ADOC #101 directed them to speak with RCC #122.

Resident care Coordinator (RCC) #122 indicated they were not aware that resident #010 needed a replacement of their safety device and that they should have been informed by staff.

The Director of Care (DOC) indicated that the home had supply of safety devices and that staff should have ensured they had all supplies available before providing care to resident #010. The DOC acknowledged that not having the safety device in use had put the resident at risk of having an injury.

Not having appropriate falls prevention devices readily available puts residents at increased risk of injury from falls.

Sources: CIS report, progress notes, and interviews PCP #113, RPN #117, RCC #122 and the DOC. [s. 49. (3)]

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. 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 :

1. 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.

A review of the home's Air Temperature and Humidex Monitoring Records from June 10 to August 12, 2021, indicated the air temperatures were not documented three times daily at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night in all residents' home areas including the designated cooling areas at the home. No Air Temperature and Humidex Monitoring Records were to be found for the period of May 15, 2021 to June 9, 2021.

The Administrator indicated no records could be found from May 15 to June 9, 2021 and acknowledged the gaps in the documentation of air temperatures not documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night in all residents' home areas including the designated cooling areas which include family rooms, TV rooms and dining rooms.

Failure to monitor the air temperatures in the home including the designated cooling areas of the home may result in uncomfortable temperatures for residents.

Sources: Air Temperature and Humidex Monitoring Records, and interview with the Administrator. [s. 21. (3)]

Issued on this 26th day of August, 2021

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) : SAMI JAROUR (570), SUSAN SEMEREDY (501)

Inspection No. /

No de l'inspection : 2021_598570_0017

Log No. /

No de registre : 024230-20, 001313-21, 003960-21, 004312-21, 004750-21, 012287-21, 012467-21

Type of Inspection /

Genre d'inspection: Critical Incident System

Report Date(s) /

Date(s) du Rapport : Aug 26, 2021

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 Woodhaven Long Term Care Residence
380 Church Street, Markham, ON, L6B-1E1

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : Andre Dwyer

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

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 :

O.Reg 79/10, s. 49. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Order / Ordre :

The licensee must be compliant with s. 49. (3) of O. Reg. 79/10.

Specifically, the licensee shall ensure the following:

- 1) Develop a process to ensure that a specified safety device are readily available at the home for residents who require them.
- 2) Keep an inventory of specified safety device to ensure sufficient supply and ensure that they are readily available at the point of care.
- 3) The home's process shall identify who is responsible to ensure sufficient supply and availability of specified safety devices at the point of care.

Grounds / Motifs :

1. The licensee has failed to ensure that a specified safety device for resident #010 was readily available for the resident.

Resident #010 sustained a fall that resulted in an injury.

Resident #010's written plan of care directed staff to ensure appropriate safety device was in use.

Personal Care Provider (PCP) #113 indicated that resident #010 did not have their safety device in use as none could be found for the resident prior to the fall incident.

Registered Practical Nurse (RPN) #117 confirmed that the resident did not have

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

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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

the safety device in use when they fell and sustained an injury. RPN #117 indicated that prior to resident #010's fall, ADOC #101 was informed that resident #010 did not have the safety device and that the ADOC #101 directed them to speak with RCC #122.

Resident care Coordinator (RCC) #122 indicated they were not aware that resident #010 needed a replacement of their safety device and that they should have been informed by staff.

The Director of Care (DOC) indicated that the home had supply of safety devices and that staff should have ensured they had all supplies available before providing care to resident #010. The DOC acknowledged that not having the safety device in use had put the resident at risk of having an injury.

Not having appropriate falls prevention devices readily available puts residents at increased risk of injury from falls.

Sources: CIS report, progress notes, and interviews PCP #113, RPN #117, RCC #122 and the DOC.

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

Severity: There was actual harm as resident #010 sustained a fall that resulted in actual harm to the resident.

Scope: This was an isolated incident.

Compliance History: In the last 36 months, the licensee had previous non compliance to different subsections.
(570)

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

Nov 26, 2021

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

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

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

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.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
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2007, c. 8

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l'article 154 de la *Loi de 2007 sur les
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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
1075, rue Bay, 11^e étage
Toronto ON M5S 2B1
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

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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

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
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 26th day of August, 2021

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : Sami Jarour

Service Area Office /

Bureau régional de services : Central East Service Area Office