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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 25, 2021	2021_875501_0023	016242-21, 017056-21	Complaint

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

SUSAN SEMEREDY (501)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 2, 3, 4, 5, 2021.

The following intakes were inspected during this complaint inspection:
Log #016242-21 and #017056-21 related to hospitalization and change of condition.

During the course of the inspection, the inspector(s) spoke with the Assistant Director of Care, Registered Practical Nurses (RPNs), Personal Care Providers (PCPs), substitute decision-maker, and residents.

During the course of the inspection, the inspector observed resident and staff interactions and IPAC practices. The inspector reviewed clinical health records, relevant home policies and procedures and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Infection Prevention and Control
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's and #002's written plan of care set out the planned care for the residents.

Resident #001 sustained injuries with an unknown cause. Evening care had been provided the previous day without respecting the resident's preference. According to the substitute decision-maker (SDM) and staff members, this preference was known and respected most of the time. Resident #001's written plan of care before the injuries did not indicate the resident's preference. An interview with the ADOC confirmed the home's expectation is for such preferences to be part of the written plan of care.

Failing to include a resident's preferences in their written plan of care puts residents at risk for receiving care that could cause loss of dignity and lead to possible responsive behaviours.

Sources: Resident #001's clinical record and interviews with the SDM and staff members. [s. 6. (1) (a)]

2. During an interview with an RPN they stated resident #002 had recently been observed to be upset when their preference was not being respected. As well, according to a PCP, resident #002's family member requested this preference on a particular day. This request was accommodated, however a review of the written plan of care indicated the resident's preference had not been included. During an interview resident #002 verified this preference.The ADOC confirmed this preference should have been made part of the resident's written plan of care.

Failing to include a resident's preferences in their written plan of care puts residents at risk for receiving care that could cause loss of dignity and lead to possible responsive behaviours.

Sources: Resident #002's clinical record and interviews with the resident and staff members. [s. 6. (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 to ensure that there is a written plan of care for each resident that sets out the planned care for the resident, to be implemented voluntarily.

Issued on this 30th day of November, 2021

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

Original report signed by the inspector.