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

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 June 20, 2022
Inspection Number 2022_1373_0002
Inspection Type
☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Chartwell Woodhaven Long Term Care Residence

Long-Term Care Home and City
Chartwell Woodhaven Long Term Care Residence, Markham

Lead Inspector
Lucia Kwok (#752)

Inspector Digital Signature
Lucia S Kwok
2022.08.11 15:03:26 -04'00'

Additional Inspector(s)
Asal Fouladgar (#751)
Najat Mahmoud (#741773) and Rexel Cacayurin (#741749) were present at the inspection.

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 2, 3, 6 to 10, 13, and 14, 2022.

The following intake(s) were inspected:
- A log related to a complaint of resident's care.

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

- Food, Nutrition and Hydration
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Safe and Secure Home
- Medication Management

INSPECTION RESULTS

WRITTEN NOTIFICATION - COMMUNICATION AND RESPONSE SYSTEM

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

Non-compliance with: O. Reg. 79/10 s. 17 (1) (a)

The licensee has failed to ensure that the resident-staff communication and response system was accessible to a resident on a specific date.

Rationale and Summary:

A complaint was submitted to the Ministry of Long-Term Care (MLTC) related to care services for a resident. According to the email communication from the resident's family to the Long-term care home (LTCH), it was discovered that the resident's call bell was not functioning on a specific day.

The home's policy titled, Resident Safety- Door Alarms, Nurse Call System and Rounds, LTC-CA-WQ-200-07-10, stated the home was to maintain and operate a nurse call system that was compliant with jurisdictional regulations.

The Environmental Services Manager (ESM) confirmed that the resident's call bell was not functioning, and the wires were replaced by a maintenance personnel on the specified date.

Impact or risk:
There was minimal risk to the resident when the call bell was not functioning.

Sources: Email communication, Interview with ESM; Home's policy titled, resident safety-door alarms, nurse call system and rounds.

[#752]

WRITTEN NOTIFICATION - NUTRITION CARE AND HYDRATION PROGRAMS

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 68 (e) (i)

The licensee has failed to ensure that a resident had their weight measured and recorded during an identified month.

Rationale and Summary

Registered Practical Nurse (RPN) #108 stated residents' weights were measured and recorded monthly between the first and seventh day of the month on a paper form, titled, "Monthly Weights and Vitals". Registered staff would review and enter the weights into the Point Click Care (PCC) system. The RPN and other staff of the home, shared that a portable Hoyer lift with a scale attachment was available in the home area which could be used to

weigh residents in their rooms. They further shared that each resident in the unit had their individual slings for the Hoyer lift.

The resident's weight during an identified month was not recorded in the paper form and their PCC records. The Registered Dietitian (RD) confirmed that the resident's weight was not recorded in the PCC system.

There was minimal risk of harm to the resident when their weight was not monitored and recorded during an identified month.

Sources: Observation, Interviews with RD, RPN #108, and staff; Resident Home Area (RHA) monthly weights and vitals during an identified month; resident's clinical records.
[752]

WRITTEN NOTIFICATION – ORIENTATION

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 218 (2) (a)

The licensee has failed to ensure that the training required under section 76 of the Act was provided to an agency staff within one week of when they began performing their responsibilities.

Rationale and Summary
A complaint was submitted to the MLTC related to an alleged staff to resident abuse incident.

Agency RPNs #111 and #112 stated that they did not receive training related to the home's policy to promote zero tolerance of abuse and neglect of residents.

The home's clinical educator, RPN #113, confirmed that there was no documentation of training records for RPN #111 for the policy to promote zero tolerance of abuse and neglect of residents. RPN #113 stated that all agency staff should have received training during their on-site orientation which included the home's policy to promote zero tolerance of abuse and neglect of residents.

There was minimal risk to residents when agency RPN #111 did not receive education from the home related to its policy to promote zero tolerance of abuse and neglect of residents.

Sources: Interviews with RPNs #111, #112, and #113, home's education and training records.
[752]

WRITTEN NOTIFICATION – PLAN OF CARE

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCH 2007, s. 6 (2)

The licensee failed to ensure that the care set out in the plan of care for a resident was based on their needs and preferences.

Rationale and Summary

The resident's clinical records indicated that resident's Substitute Decision Maker (SDM) requested a specific positioning of their bed for the resident's comfort. RPN #109 and Personal Support Worker (PSW) #114 expressed acknowledgement about the SDM's request.

In the resident's plan of care, their preference about the positioning of the bed was not documented and specified.

The Director of Care (DOC) confirmed that the SDM's request was part of the resident's plan of care and should have been documented in their care plan.

There was minimal risk of harm to the resident when their care plan did not contain information related to their specific preferences.

Sources: Interviews with RPN #109, PSW #114, DOC, resident's clinical records.
[751]

WRITTEN NOTIFICATION – PLAN OF CARE

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCH 2007, s. 6 (9) (1)

The licensee failed to ensure that the provision of the care set out in the plan of care for a resident was documented.

Rationale and Summary
A complaint was submitted to MLTC related to the resident's specific care provision during an identified date when the home was in a specific outbreak.

The resident's Point of Care (POC) for a specific month, related to an identified care provision was missing documentation on multiple occasions.

PSW #118 stated the expectation was to document in POC if the resident refused care. PSW #118 also stated that the resident rarely refused care and at times the POC system had technical issues, however, it could not be confirmed if resident was provided with that specific care based on the missing documentations in POC.

RPN #109 confirmed that staff were supposed to document the care provided to the resident in POC and according to the missing documentations, it could not be ascertained if the resident was provided with the care.

The DOC stated that staff were able to continue the identified provision of care during the home's outbreak if residents were not sick and able to wear an identified personal protective equipment (PPE). The DOC also confirmed that staff were expected to document in POC when the care was provided to the resident.

There was minimal risk of harm to the resident when the provision of care provided to them was not documented in POC.

Sources: Interviews with RPN #109, PSW #118, DOC, resident's clinical records.
[#751]

WRITTEN NOTIFICATION – ADMINISTRATION OF DRUGS

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 131 (1).

The licensee failed to ensure that a medication which was administered to a resident was prescribed for them.

Rationale and Summary

RPN #112 documented in the resident's progress notes that they had developed a medical condition but were unable to take their medication specified for that condition. The RPN had to call the on-call physician to obtain an order for the same medication with a different route of administration as the resident did not have an order for it.

Review of the resident's electric Medication Administration Record (eMAR) and physical chart indicated the resident did not have an order for the same medication with a different route of administration.

RPN #112 stated they did not receive a call-back from the on-call physician and the resident's SDMs declined to transfer the resident to hospital. RPN #112 stated they administered the medication as per direction from the Charge nurse.

The home's medication administration policy indicated that all medications and treatments must have an order by the resident's Attending Physician or Nurse Practitioner before administration.

There was minimal risk to the resident as the home did not follow their policy on medication administration.

Sources: Interviews with RPN #112, resident's eMAR, progress notes, physician's order sheets from the physical chart, home's medication administration policy.

[751]

WRITTEN NOTIFICATION - POLICY TO PROMOTE ZERO TOLERANCE

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA 2007, s. 20 (1)

The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary
A complaint was submitted to MLTC related to a resident being treated inappropriately during care.

The resident's clinical records indicated that the SDM reported to the registered staff that they observed the resident being treated inappropriately by staff on their recording device. There was no further documentation related to the family's statement in resident's clinical records.

The home's policy titled, Abuse allegations and follow-up, indicated that all employees are required to, as a component of Chartwell's internal reporting structure to ensure safety for all, report immediately to their respective supervisor/person in charge of the building when: At any time information or knowledge of an allegation of an abuse is received or learned from any person.

RPN #109 and Registered Nurse (RN) #120, confirmed that the statement made by family was considered an allegation of abuse and had to be reported to the home's management for further investigation and follow-up. RPN #111 stated they reported the same to the charge nurse and physician.

The DOC stated they did not receive a report regarding the alleged abuse and according to the home's policy, staff must report the same to the home's management.

There was potential risk for the resident as the home did not comply with their policy of prevention of abuse and neglect of a resident as it could delay the process of the home's investigation into the reported alleged abuse.

Sources: Interviews with RPNs #109 and #111, RN #120, and DOC, home's policy titled, Abuse Allegations and Follow-Up, resident's clinical records.
[751]

WRITTEN NOTIFICATION - TRANSFERRING AND POSITIONING TECHNIQUES

NC#008 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 36.

The licensee failed to ensure that staff used safe positioning techniques when assisting a resident.

Rationale and Summary

A photo was submitted to MLTC related to a resident being assisted in their assistive device using inappropriate technique. According to the resident's SDM, the resident's assistive device had been modified and did not require additional adjustment to assist them with positioning in their assistive device.

The Occupational Therapist (OT)'s progress notes indicated that the modification to the resident's assistive device would improve their comfort. The OT progress notes further indicated the resident received a new assistive device with the identified modification.

The OT stated that the modification was recommended based on the resident's condition and they would not recommend other adjustments to the resident's assistive device as it would not be a safe positioning technique.

There was potential risk to the resident as the staff did not use safe positioning technique when assisting them.

Sources: Interviews with OT, resident's clinical records. [751]

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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 or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator

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

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

Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
email: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.

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

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