Ontario

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

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

Central East District
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Original Public Report

Report Issue Date: May 29, 2024

Inspection Number: 2024-1373-0002

Inspection Type:
Complaint
Critical Incident

Licensee: Regency LTC Operating Limited Partnership, by it general partners, Regency Operator GP Inc. and AgeCare Iris Management Ltd.

Long Term Care Home and City: AgeCare Woodhaven, Markham

Lead Inspector	**Inspector Digital Signature**
Jennifer Brown (647)	Jennifer Brown

Additional Inspector(s)
Asal Fouladgar (751)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 29-30, 2024 and May 1-2, 6-9, 2024.

The following intake(s) were completed in this inspection:

- Intakes: #00021674, #00090754, and #00109477 - related to prevention of abuse and neglect,
- Intakes: #00096576, #00104169, and #00110936 - related to a fall that resulted in injury,
- Intakes: #00102517, #00110340, and #00112267 - related to an injury of unknown cause,
- Intake: #00108265 - related to a missing resident,

Intake: #00109757 - related to responsive behaviors and bedtime rest routines, and
Intake: #00113228 - related to staffing, responsive behaviors, nutrition and hydration, and recreational and social activities.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Recreational and Social Activities
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

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

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents were not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from abuse by a Personal Support Worker (PSW).

Section 2 of the Ontario Regulation 246/22 defined physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain", and emotional abuse as "any threatening, insulting, intimidating or humiliating gestures, actions, behavior or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident".

Rationale and Summary

A Critical Incident Report (CIR) was submitted that indicated a resident reported to a Registered Nurse (RN), and a Registered Practical Nurse (RPN) that they were assaulted by a PSW.

The resident stated that the PSW provided rough care to them. When the resident reached out to the phone to "call for help", the PSW pulled the phone away from their hand and threatened the resident.

Please note, the PSW was not present at the time of this inspection.

The home's investigation notes and interviews with the RN and Director of Care (DOC) indicated that the PSW was physically and emotionally abusive to the resident as they provided rough care to the resident. When the resident became upset and resisted care, the PSW threatened the resident to call the "police" on them.

As a result of the PSW providing rough care to the resident, the resident sustained an injury.

Sources: Resident's clinical record, Critical Incident Report (CIR), the home's investigation notes, interviews with the resident, RN's, RPN, and the DOC. [751]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident had occurred, immediately reported the suspicion and the information to the Director.

Rationale and Summary

A CIR was submitted to the Director related to an allegation of staff to resident physical and verbal abuse.

A PSW stated they observed the incident, however they did not report this incident immediately to the charge nurse. The incident was first reported through the INFOLINE several hours after on the same day.

The resident's clinical records indicated pain and skin assessment conducted by registered staff after the INFOLINE was called.

Failure to immediately report an incident of physical or verbal abuse of a resident, put them at further risk of harm by the accused staff.

Sources: CIR, the home's investigation notes, resident's clinical record, and interviews with staff. [751]

WRITTEN NOTIFICATION: Falls prevention and management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to ensure that, the implementation of the use of equipment, supplies, devices and assistive aids for a resident.

Summary and Rationale

A CIR was submitted that indicated, a resident sustained a fall that resulted in an injury.

A resident was observed in a chair in the TV lounge. The chair was equipped with a

fall prevention strategy device; however the fall prevention strategy device was not connected.

The plan of care for the resident indicated that the resident was a high risk for falls and was required to have the device in place while they were in their chair due to previous agitation and previous fall with injury.

An RPN confirmed the resident's high fall risk and previous fall risk, and further indicated that the device was required to be connected to alert staff in the event that the resident were to get agitated, attempt to climb out of their chair, or fall.

There was a risk to the resident when the device was not connected due to the resident's high risk of falls and previous fall that resulted in an injury. Staff would not be alerted to the resident falling out of the chair without these connected.

Sources: CIR, Plan of Care, observations, interviews with an RPN and PSW. [647]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Specifically, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, s. 9.1 (f) states required at a minimum, that Additional Precautions included appropriate selection, and application of Personal Protective Equipment (PPE) was followed.

Rationale and Summary

A resident in isolation, was observed sitting in their room with a visitor. The visitor was not wearing the required PPE.

An RPN verified that the resident was visiting with their Substitute Decision Maker (SDM) in the isolation room. The SDM had been informed that the resident was under additional precautions, there was signage posted on the resident's door, and PPE was supplied along with donning and doffing instructions.

The clinical health record confirmed that the resident was in isolation precautions.

Failing to ensure that visitors at the home apply appropriate PPE when entering additional precaution rooms, placed the home at risk of spreading infections.

Sources: Visitor observation and staff interview. [751]