Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 2, 2018	2018_767643_0019	008280-17	Complaint

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

Long-Term Care Home/Foyer de soins de longue durée

Chartwell Wenleigh Long Term Care Residence
2065 Leanne Boulevard MISSISSAUGA ON L5K 2L6

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

ADAM DICKEY (643)

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): September 21, 24 and 25, 2018.

During the course of the inspection, the inspector(s) spoke with the Administrator, Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

During the course of the inspection the inspector conducted observations of staff to resident interactions and the provision of care, conducted review of resident health records, training records and materials and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 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	Legendé 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the residents' right to have his or her

participation in decision-making was fully respected and promoted.

A written complaint from resident #002 was forwarded to the Director of the Ministry of Health and Long-Term Care (MOHLTC) under LCTHA, 2007, c. 8, s. 22 (1), concerning an allegation of abuse. The written complaint indicated that on an identified date, resident #002 had been scheduled for a specified activity of daily living (ADL), but had indicated to staff that they did not want to take part in the activity as scheduled. The letter indicated that staff pushed resident #002 into a specified area of the resident home area and completed the specified ADL despite the resident's indication they did not want to complete the activity.

In an interview, resident #002 indicated that they had discussed with the PSW assigned to their care that they would assist the resident with the specified ADL at an identified time. Resident #002 indicated the PSW was not available until approximately 30 minutes after the agreed upon time, and at that time the resident indicated they were concerned it was no longer safe for them to complete the ADL. Resident #002 indicated that this was overheard by RN #103, who dismissed the concern from resident #002 and pushed them to a specified area in the resident home area and continued to assist them with the ADL despite the resident telling them no.

PSW #102 and RN #103 were not available for interview at the time of inspection.

Review of a written statement from PSW #102 showed resident #002 had indicated they had given identified reasons, and did not want to continue with the ADL. The statement from PSW #102 indicated they had told RN #103 that resident #002 did not want to complete the ADL and to leave them, RN #103 said it was okay and would help PSW #102. PSW #102's statement indicated they listened to RN #103 and completed the ADL so RN #103 would not be able to say the PSW was lazy.

In an interview, Administrator #101 indicated that when a resident refuses care or treatment they should leave the resident and re-approach. The Administrator further indicated that PSW staff should report to the registered staff and take directions from them. The Administrator indicated that care staff should not force residents to have care, and that resident #002 had reasons for refusing the above mentioned ADL and staff should have taken directions from the resident for their care. The Administrator acknowledged that resident #002's right to have their participation in decision-making was not fully respected and promoted. [s. 3. (1) 9.]

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 with ensuring that the residents' right to have his or her participation in decision-making is fully respected and promoted, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by staff that resulted in harm or risk of harm had occurred immediately reported the suspicion and the information upon which it was based to the Director.

A written complaint from resident #002 was forwarded to the Director of the Ministry of Health and Long-Term Care (MOHLTC) under LCTHA, 2007, c. 8, s. 22 (1), concerning an allegation of abuse. The written complaint indicated that on an identified date, resident #002 had been scheduled for a specified ADL, but had indicated to staff that they did not want to take part in the activity as scheduled. The letter indicated that the resident had pain after completing the ADL, when they had verbally refused the activity.

Review of a Disciplinary Action Form for RN #103 dated five days following the above mentioned incident, indicated that an allegation of abuse was brought forward to management regarding an incident with a resident in an identified resident home area. The letter further indicated the investigation concluded RN #103's actions constituted abuse toward the resident.

In an interview, Administrator #101 indicated that the letter received from resident #002 was considered an allegation of abuse. The Administrator indicated that the expectation would be for allegations of resident abuse to be reported right away to the Director of the MOHLTC. The Administrator acknowledged that the allegation of abuse of resident #002 was not immediately reported to the Director. [s. 24. (1)]

Issued on this 4th day of October, 2018

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

Original report signed by the inspector.