

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de
Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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
Oct 29, 2021	2021_631210_0026	008136-21, 011425-21	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 Wenleigh Long Term Care Residence
2065 Leanne Boulevard Mississauga ON L5K 2L6

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

SLAVICA VUCKO (210)

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): October 14, 15, 25 and 26, 2021.

The following Critical Incident System (CIS) reports were completed during this inspection:

-Log #008136-21 (CIS # 2833-000005-21) related to hospitalization and change in health status of a resident and

-Log #011425-21 (CIS #2833-00008-21) related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Physiotherapist (PT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Infection Prevention and Control (IPAC) lead.

During the course of the inspection, the inspector conducted observations of the home, including resident home areas, staff to resident interactions, reviewed internal investigation notes, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention

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

<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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #001.

A Critical Incident System (CIS) report was submitted to Ministry of Long Term Care (MLTC) that resident #001 sustained an injury from unknown cause for which they required treatment in hospital.

The written plan of care of resident #001 indicated two staff to provide extensive assistance for all transfers, and when necessary sit-stand lift to be used. As per the home's policy the lifts are to be used by two staff.

Two different staff transferred the resident at two different occasions by one person. On a specified date, the resident presented with symptoms of pain and swelling. The resident was transferred to hospital for treatment of an injury.

Resident #001 was not transferred safely with two person assistance during the activities of daily living.

Sources: review of resident #001's clinical record (written plan of care, progress notes, transfer assessments), interview with staff (personal support workers, registered staff, physiotherapist and other staff) review of home's investigation notes, the home's policy Mechanical lifts and Resident Transfers, revised July 2019. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 4th day of November, 2021

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

Original report signed by the inspector.