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

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Original Public Report

Report Issue Date September 14, 2022
Inspection Number 2022_1318_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner

Long-Term Care Home and City
Chartwell Wenleigh Long Term Care Residence, Mississauga, ON

Lead Inspector
Adelfa Robles (723)

Inspector Digital Signature
Adelfa P Robles
2022.09.15 12:09:02 -04'00'

Additional Inspector(s)
Adam Dickey (643) attended the inspection as an assessor

INSPECTION SUMMARY

The inspection occurred on the following date(s): September 1, 2, 7 and 8, 2022, onsite; September 6, 2022, offsite.

The following intake(s) were inspected:

- Log #001032-22 (Critical Incident System (CIS) #2833-000002-22) related to fall with injury

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#01 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 6 (10) b

The licensee failed to ensure that a resident's plan of care was revised when their care needs changed.

A positioning device was observed in a resident's room. Staff confirmed that the device was used as a falls prevention intervention and was not indicated in the plan of care.

The plan of care was revised to include the device as falls intervention.

Sources:
Observations of resident's room, review of clinical records and staff interviews.

Date Remedy Implemented: September 7, 2022

[723]

NC#02 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021 s. 6 (10) b

The licensee failed to ensure that a resident's plan of care was revised when a therapeutic device was no longer necessary.

A resident had a fall and sustained an injury. The resident was to use a device for six weeks and the plan of care was not revised. Staff stated that the resident no longer used the therapeutic device and was discontinued.

The resident's written plan of care was revised to reflect their current care needs.

Sources:
Observation of a resident, review of resident's clinical records and staff interviews.

Date Remedy Implemented: September 6, 2022

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WRITTEN NOTIFICATION PLAN OF CARE

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 *s. 6 (7)*

The licensee failed to ensure that a resident's intervention to prevent injury from falls was provided as specified in the plan.

Rationale and Summary
A CIS was submitted by the home when a resident had a fall and sustained an injury.

The resident was at risk for falls and was to wear a safety device to minimize injury in case of fall. During inspection, the resident was observed not wearing the device as per the plan of care.

Staff indicated that the resident was not wearing the device as required and plan of care was not followed. Assistant Director of Care (ADOC) stated that staff were expected to follow resident's plan of care.

There was an increased risk of injury from falls when a falls intervention was not provided to a resident as specified in the plan.

Sources:
Observations of a resident, review of clinical records and staff interviews.

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WRITTEN NOTIFICATION MINIMIZING OF RESTRAINING

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 *s. 34 (1) 3*

The licensee has failed to ensure that a resident was not restrained by the use of a physical device, other than in accordance with FLTCA, 2021 s. 35.

Rationale and Summary
A resident appeared agitated when observed in the unit's hallway and asked an Inspector to remove their physical device. The resident was directed to a staff for assistance. The staff did not remove the device, attempted to redirect the resident, and stated that the resident was at risk for falls. Another staff stated the resident always had the device. Both staff stated the device was indicated as a restraint. Interview with ADOC stated that there was no physician order for the device.

Additional observations showed the resident had the device when not required to assist the resident. Staff working in the unit stated that the resident always had the device in place. A registered staff stated that resident required the device for safety.

The home's Physical Restraint Policy indicated that consent for physical restraint, physician's order as well as care plan indicating the use of restraint, type of restraint, reason for use and when to be applied were required prior to application of restraint to a resident.
Resident's PT assessments from October 2021 to July 2022, indicated physical restraint using the device as falls prevention. There was no physician order or consent signed by the resident

or the resident's Substitute Decision Maker (SDM) for a restraint. Progress notes from September 2021 to September 2022 indicated that resident would call out and try to remove the device. Point of Click Care (PCC) task list indicated the device as a restraint. The resident's written plan of care did not indicate the use of the device as a restraint.

The Director of Care (DOC) stated that a physician's order, consent signed for application of restraint and care plan indicating the type of restraint, reason for use and how to apply should be included in the resident's plan of care if on restraint.

There was a risk of worsened agitation and confusion when a resident was restrained using a physical device.

Sources:
Observations of a resident, clinical records, home's policy titled "Physical Restraint" LTC-CA-WQ-200-07-19 revised December 2017, and staff interviews.

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WRITTEN NOTIFICATION MINIMIZING OF RESTRAINING

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 *s. 120 (1)*

The licensee failed to ensure that a resident's Personal Assistance Services Device (PASD) was removed when not in use.

Rationale and Summary
A resident was observed multiple times in various times of day. The resident was observed with their physical device in place even without any activity.

The home's PASD policy indicated that the PASD was removed as soon as it was no longer required to provide such assistance unless the resident requested. Documentation was required in the resident's care plan to indicate clear instructions on the application and removal of the PASD.

A resident's written plan of care indicated PASD during activities and mealtimes. There were no instructions on the removal of the PASD.

Staff stated that the resident always had the device in place. ADOC stated that the device was indicated as a PASD, and staff were expected to remove the resident's PASD when the resident requested and when not in use.

There was a risk of increased restlessness for a resident when their PASD was not released when not in use.

Sources:
Observations of a resident, clinical records, home's policy titled "PASD" LTC-CA-ON-200-07-18 revised December 2017 and staff interviews.

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WRITTEN NOTIFICATION ADMINISTRATION, MISCELLANEOUS

NC#06 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 184 (3)

The licensee failed to comply with Minister's Directive: COVID-19 response measures for long-term care homes, published April 27, 2022, requiring licensee to ensure that COVID-19 Screening was completed at a minimum in accordance with the COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes, effective August 31, 2022, when the home's screeners did not ask all the COVID-19 active screening questions in the home's Employee COVID-19 (Coronavirus) Screening Log.

Rationale and Summary
Observations of the home's active screening at entry identified that the screener asked four out of the six questions from the home's COVID-19 active screening log when inspectors entered the home. Further observations identified that another screener asked two out of the six questions from the home's COVID-19 active screening log. Both screeners did not ask all the COVID-19 symptoms listed in the home's Employee COVID-19 (Coronavirus) Screening Log.

Screeners and the IPAC lead stated that all of the six COVID-19 screening questions including all of the symptoms related to COVID-19 should be asked to individuals prior to entry into the home.

There was an increased risk for potential exposure to COVID-19 when staff failed to actively screen visitors for symptoms and exposure history for COVID-19.

Sources:
September 1, 2022, observations, Minister's Directive: COVID-19 response measures for long term care homes, published April 27, 2022, COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes Version 13-August 31, 2022, home's Employee COVID-19 (Coronavirus) Screening Log (ON-LTC) and staff interviews.

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WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#07 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 *s. 102 (2) b*

The licensee failed to ensure that additional precautions were followed in the IPAC program.

The licensee failed to implement measures in accordance with the IPAC Standard for Long Term Care Homes April 2022 (IPAC Standard). Specifically, the IPAC lead failed to provide environmental controls for residents requiring additional IPAC precaution at point of care as required by Additional Requirement 9.1 under the Standard.

Rationale and Summary
Observations were made in different resident home areas. Four resident rooms had contact precaution signage posted, with Personal Protective Equipment (PPE) caddies hung on the residents' doors. The gloves required as part of these additional IPAC precautions were not available in the point of care caddies. IPAC lead stated that all the required PPE including gloves were expected to be available at point of care.

Failure to provide PPE in accordance with the additional precautions at point of care increased the risk of infection transmission.

Sources:
Observations in resident home areas, home's List of Residents on IPAC Precaution dated September 1, 2022, IPAC Standard for Long Term Care Homes, April 2022, and staff interviews.

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WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#08 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 *s. 102 (8)*

The licensee failed to ensure that staff participated in the implementation of the IPAC program when staff did not perform hand hygiene before and after contact with a resident and their environment.

Rationale and Summary
The home's Hand Hygiene Program, revised August 2022, under procedures indicated that hand hygiene to be performed before initial contact with the resident or resident environment as well as after resident or resident environment contact as per the "Four Moments of Hand Hygiene".

Observations in a resident home area showed a staff did not perform hand hygiene prior to assisting a resident in their room. Another staff did not perform hand hygiene after leaving the same resident's room. The resident subsequently tested positive for COVID-19 the following day.

Staff and the IPAC lead stated that staff were expected to perform hand hygiene prior to and after contact with the resident and their environment.

Failure to perform hand hygiene before initial contact and after contact with resident or resident environment increased the risk of transmission of infection.

Sources:
September 1, 2022, observations, the home's policy titled "Hand Hygiene Program" LTC -CA-WQ-205-02-04 and staff interviews.

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