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

Hamilton District
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Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: October 13, 2023

Inspection Number: 2023-1318-0004

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 Wenleigh, Mississauga

Lead Inspector	**Inspector Digital Signature**
Daria Trzos (561)	Daria Trzos Digitally signed by Daria Trzos Date: 2023.10.20 09:57:57 -04'00'

Additional Inspector(s)
Parminder Ghuman (706988)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 31, 2023 and September 1, 5, 6, 8, 13-15, 18-20, 22, 26, 27, 2023.

The following intake(s) were inspected:

- Intake: #00088951 - Critical Incident (CI) - Improper/Incompetent treatment of a resident.
- Intake: #00089645 - CI - Controlled substance missing/unaccounted for.
- Intake: #00090698 - CI - Fall of a resident with injury.
- Intake: #00093108 - Complainant related to multiple care concerns.
- Intake: #00096156 - Complainant related to multiple care concerns and home not complying with complaints process.

The following intakes were completed in this inspection: Intake #00021664, CI#2833-000002-23, Intake #00086351, CI#2833-0000004-23 and Intake #00094210, CI#2833-000018-23 were related to falls.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care Reassessment

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (11) (b)

The licensee has failed to ensure that when a resident was reassessed post falls, different approaches were considered in the revision of their plan of care when initial interventions were not effective.

Rationale and Summary
A resident sustained a fall with injury and after the fall several interventions were implemented to prevent falls. Clinical records indicated that since the implementation of one of these interventions the resident had behaviours of removing it. The resident sustained more falls and one of them led to another injury. When the resident returned to the home from hospital, the home continued to use the same intervention despite the resident frequently removing it.

When Inspector #561 visited the resident during inspection the intervention was still being used and on one of the visits the intervention was removed by the resident. The Assistant Director of Care (ADOC)/Falls Lead stated that they had another specific intervention in the home, but they had not tried it for this resident when the other one was not effective.

Failing to consider other approaches when the initial intervention for falls prevention was not effective may have increased the risk for injury.

Sources: Observations; record review including investigation notes, progress notes, care plan and falls

committee meeting minutes; interviews with staff.
[561]

WRITTEN NOTIFICATION: Involvement of SDM

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee has failed to ensure that a resident's substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary
Resident's substitute decision-maker (SDM) was not informed of the resident's altered skin integrity. There was a progress note made which indicated that a day nurse was to notify resident's SDM of the altered skin integrity; however, that was not done.

Not notifying the family of the altered skin integrity meant that family were not given the opportunity to participate fully in the plan of care.

Sources: Review of resident's progress notes; interviews with staff.
[706988]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care was provided to a resident as specified in the plan related to toileting.

Rationale and Summary
The plan of care for a resident indicated that they required an identified level of assistance with toileting and they were assessed to be at high risk for falls. The plan of care was not followed, and the resident sustained a fall with injury. This was confirmed by the Administrator.

Failing to follow the plan of care in relation to toileting increased the risk for the resident's injury.

Sources: Review of the investigation notes, resident's records; interview with staff.
[561]

WRITTEN NOTIFICATION: Complaints Procedure

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The licensee has failed to ensure that long-term care home immediately forwarded any written complaint that it received concerning the care of a resident to the Director.

Rationale and Summary
A resident's family brought written care concerns for the resident to the home which were not forwarded to the Director. Interviews with ADOC and Administrator confirmed that home had not submitted the written care concerns to the Director.

Sources: Review of resident's progress notes, Complaints policy (revised April 2022); and interviews with staff.
[706988]

WRITTEN NOTIFICATION: Directives by Minister

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to comply with the Minister's Directive: COVID-19 Guidance Document for Long-Term Care Homes in Ontario, effective June 26, 2023, when Infection Prevention and Control (IPAC) audits were not completed at least quarterly when not in outbreak.

Rationale and Summary
It was identified that the latest IPAC audit the home completed was on May 24, 2023. The IPAC Lead believed they were to be completed every six months when not in outbreak.

Failing to complete the IPAC audits at least quarterly may have increased the risk for the home not being able to identify IPAC issues and address them in timely manner.

Sources: Review of the IPAC audits binder; interview with the IPAC lead.
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WRITTEN NOTIFICATION: Admission Care Plan

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (6)

The licensee has failed to ensure that the care set out in the 24-hour admission care plan was provided to a resident as specified in the plan.

Rationale and Summary
A resident's 24-hour admission care plan stated that staff were to initiate seven day pain flowsheet. This pain assessment was not completed. In an interview with registered staff, they stated that they were aware of the care plan, but care plan was not followed for this resident. Interviews with Director of Care (DOC) and review of the plan of care confirmed that staff failed to follow the resident's plan of care for pain assessment.

Not having the pain assessment completed posed a risk for pain management of the resident.

Sources: Review of resident's plan of care, interviews with staff.
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WRITTEN NOTIFICATION: Skin and Wound Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee has failed to ensure that a resident received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument in relation to an altered skin integrity.

Rationale and Summary
A progress note stated a skin assessment was initiated for a resident. Clinical records were reviewed which identified that the skin assessment was never completed.

Not completing the skin assessment could have impacted the treatment plan for the altered skin integrity.

Sources: Review of resident's skin assessments, progress notes; interviews with staff.
[706988]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1)

The licensee has failed to ensure that written care concerns for the resident were dealt with.

Rationale and Summary
A resident's family brought written care concerns for the resident to the home. The care concerns were not investigated, resolved and no response was provided to the complainant. Interviews with ADOC and Administrator confirmed that staff failed to follow the process for dealing with complaints.

Not following the home's complaints process resulted in the resident's SDM not receiving follow-up on their concerns.

Sources: Review of resident's progress notes, Complaints Policy (revised April 2022); interviews with staff.
[706988]

WRITTEN NOTIFICATION: Reporting re: Critical Incidents

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 3.

The licensee has failed to ensure that the Director was informed of a missing controlled substance in the home no later than one business day after the occurrence of the incident, followed by the report.

Rationale and Summary
A missing controlled substance was identified by registered staff. The DOC of the home was informed by the registered staff immediately; however, the Critical Incident (CI) was not reported to the Director until several days later.

Sources: Review of the CI; interviews with staff.
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WRITTEN NOTIFICATION: Policy for Medication Management

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)

The licensee has failed to comply with the process of counting controlled substances at shift change and reporting any incidents of missing narcotics to ensure accurate acquisition, dispensing and receipt of the drugs in the home.

In accordance with O. Reg. 246/22 s. 11(1)(b), the licensee is required to ensure that there is a policy and procedure in place to ensure the accurate acquisition, dispensing and receipt of controlled substances in the home and that it must be complied with.

Rationale and Summary
Specifically, registered staff failed to comply with the home's Narcotics policy, revised December 2017, which indicated that at shift change two registered staff were to complete a count of all controlled drugs for all residents and document this on the individual Narcotic Record. Upon receipt of a new narcotic or controlled drug, the nurse was to confirm the amount of drug received and document this on the form. Any discrepancies were to be reported immediately to the Director of Care or designate.

On an identified date, registered staff did not count the narcotics together at shift change. A new card with controlled substances that arrived from pharmacy, when counted by evening nurse had one missing pill; however, that staff member documented that the card had all pills in it. They failed to report this to anyone and left their shift. The DOC acknowledged that the home's policy for counting narcotics at shift change and not notifying the nurse in charge immediately of the missing narcotic by the evening nurse was not followed.

Failing to follow the process for narcotic counting at shift change increased the risk for medication errors.

Sources: Review of the CI, review of the investigation notes and the Narcotics policy (revised December 2017); interview with staff.
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WRITTEN NOTIFICATION: Safe storage of drugs

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (b)

The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Rationale and Summary
Narcotics were delivered to the home by pharmacy and a nurse in charge brought the medications to one of the units. The narcotics were not stored in a locked area within the locked medication cart until the nurse left their shift.

Failing to store narcotics that were received from pharmacy in a double locked area increased the risk of unsafe storage of the narcotics.

Sources: Review of the CI, investigation notes, Receiving Narcotic and Controlled Medications Policy (effective Sept 29, 2022, revised June 30, 2023); interviews with staff.
[561]

WRITTEN NOTIFICATION: Retraining

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 260 (1)

The licensee has failed to ensure that staff who provided direct care to residents received annual training in 2022 related to falls prevention.

Rationale and Summary
Training records from Surge Learning indicated that 109 out of 170 direct care providers (Registered staff and PSW staff) which accounted for 64.1 Per Cent (%), completed training on Falls Prevention in 2022. This was acknowledged by the DOC.

Sources: Review of training records and interview with DOC.
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