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

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Original Public Report

Report Issue Date: March 20, 2024
Inspection Number: 2024-1318-0001
Inspection Type: Proactive Compliance Inspection
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**
Dusty Stevenson (740739)	Dusty Stevenson Digitally signed by Dusty Stevenson Date: 2024.04.03 16:00:12 -04'00'

Additional Inspector(s) Emmy Hartmann (748)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 15-16, 20-23, 26-29, 2024

The following intake(s) were inspected:

- Intake: #00107336 - Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils

Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and 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 #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident;

The licensee has failed to ensure that the written plan of care for two residents had clear directions to staff related to bathing.

Rationale and Summary

A: A resident identified to inspector #748 that they preferred to have showers.

The resident's care plan and the home's bathing list did not identify the resident's preference for bathing.

The Director of Care (DOC) identified that the home used the care plan to give directions to staff related to care, and that the preference for bathing should be included in the care plan.

The resident's preference for bathing was added on an identified date.

Sources: Resident's care plan, Neighbourhood Bathing List; interview with the DOC. [748]

B: A resident's Power of Attorney (POA) identified to the inspector that the resident preferred to have showers.

The resident's care plan and the home's bathing list did not identify the resident's preference for bathing.

The DOC identified that the home used the care plan to give directions to staff related to care, and that the preference for bathing should be included in the care plan.

The resident's preference for bathing was added on an identified date.

Sources: Resident's care plan, Neighbourhood Bathing List; interview with the DOC.

[748]

Date Remedy Implemented: February 22, 2024

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's POA was given the opportunity to participate fully in the development and implementation of the resident' s plan of care when there were changes.

Rationale and Summary
A resident had a new skin impairment on a day in November, 2023, requiring a treatment. On a day in December, 2023, the resident received an order for a change in a medication; and on a day in February, 2024, the resident received a new medication order.

During a review of the resident's physician's orders and progress notes, there was no documentation related to the notification of the resident's POA for the above changes.

The DOC verified that the resident's POA should have been notified.

The resident's POA was not given the opportunity to participate in the development and implementation of the resident's plan of care, which could have resulted in the resident's plan not being individualized to their needs.

Sources: Resident's progress notes, skin and wound assessments, physician's orders; interview with RN #103, and the DOC. [748]

WRITTEN NOTIFICATION: Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of the care set out in the plan of care was documented for two residents.

Rationale and Summary
A: A resident care plan identified that they required a level of assistance with dressing, personal hygiene, toileting, transferring and bathing.
A review of the documentation of care provided to the resident in during a specific period of time identified that the resident was provided a different level of assistance for 12 days for personal hygiene, for 13 days for dressing, for four days for toileting, and for three days for bathing.

The DOC verified that the staff members who documented the care, provided the correct assistance to the resident but did not correctly document the care that was

provided in Point Click Care (PCC).

There was a risk to the continuity of care of the resident, when the care that staff provided was not documented correctly.

Sources: Resident's care plan, Documentation Survey Report; interview with the DOC. [748]

B: A resident's care plan identified that they required a level of assistance with dressing, personal hygiene, toileting, transferring and bathing.
A review of the documentation of care provided to the resident during a specific period of time identified that the resident was provided a different level of assistance for personal hygiene for 18 days, and for toileting for five days. There was no documentation for three days for personal hygiene, toileting, transferring, and there was no documentation of the bathing the resident was provided on one day.

The DOC verified that the staff members who documented the care, provided the correct assistance to the resident but did not correctly document the care that was provided in Point Click Care (PCC).

There was a risk to the continuity of care of the resident, when the care that staff provided was not documented correctly.

Sources: Resident's care plan, Documentation Survey Report; interview with the DOC. [748]

WRITTEN NOTIFICATION: Retraining

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 82 (4)
Training
s. 82 (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

The licensee has failed to ensure that staff were retrained annually in the home's policy to promote zero tolerance of abuse and neglect of residents.

Rationale and Summary
Training records for 2023 identified that 147 of 178 staff were re- trained in 2023. The Administrator verified that all staff were not re-trained in the home's policy to promote zero tolerance of abuse and neglect of residents.

There may have been a risk to residents if all staff were not re-trained on the home's policy to promote zero tolerance of abuse and neglect of residents.

Sources: Training Records for the Home's Policy to promote zero tolerance of abuse and neglect for 2023; interview with the Administrator.
[748]

WRITTEN NOTIFICATION: Binding on licensees

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee has failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, when the home failed to followed direction from their local public health unit regarding N95 masking during a COVID-19 outbreak.

Rationale and summary

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, and the COVID-19 guidance document for long-term care homes in Ontario, updated March 4, 2024, homes must follow any guidance provided by their local public health unit with respect to any additional measures that must be implemented to reduce the risk of COVID-19 transmission in the setting. Specifically, the IPAC Lead failed to implement N95 masking for staff when they interacted with suspected and confirmed cases of COVID-19.

The home submitted a Critical Incident Report that indicated a COVID-19 outbreak was declared in the home on a day in February, 2024.

On a day in February, 2024, a staff was working in one of the homes areas affected by the COVID-19 outbreak. They indicated to inspector #740739 that they were not required to wear a N95 mask when interacting with a resident that was positive for COVID-19 and were directed that it was an individual choice. N95 masks were not observed in personal protective equipment (PPE) caddies at point of care for residents who were positive for COVID-19.

In an interview with the IPAC Lead they indicated it was not necessary to wear an N95 when interacting with a suspected or confirmed case of COVID-19.

In an email correspondence with the home's local public health unit it indicated the use of N95 masks were to be used as a control measure to prevent the spread of the virus.

The IPAC Lead later acknowledged that staff should be wearing and N95 masks when interacting with suspected or confirmed cases of COVID-19.

Failing to wear a N95 mask when indicated may increase the risk of spread of COVID-19.

Sources: interviews IPAC Lead and staff; record review of email guidance from Public Health Unit, dated February, 2024; Minister's Directive: COVID-19 response measures for long-term care homes, and the COVID-19 guidance document for long-term care homes in Ontario. [740739]

WRITTEN NOTIFICATION: Doors in a home

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,

The licensee has failed to ensure that the third floor door which lead to a balcony, was kept locked.

Rationale and Summary

During the initial tour of the home, the third floor door in an identified home area was observed to be unlocked.

Three staff members verified that the door was unlocked, and should have been locked.

There may have been a risk to the safety of residents when the door leading to the balcony was kept unlocked.

Sources: Observation on February 15, 2024; interviews with staff and Environmental Services Manager. [748]

WRITTEN NOTIFICATION: Communication and response system

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee has failed to ensure that the home's communication response system was easily seen and accessible to two residents at all times.

Rationale and Summary
A: A resident's call bell cord was placed out of reach, behind the bed while the

resident was laying in bed. The resident verified that they could not see or reach their call bell.

The resident required staff assistance for all aspects of their care, and not being able to see or access their call bell could have resulted in the resident not getting assistance when needed.

Sources: Resident's care plan; observations, interview with resident. [748]

B: A resident's call bell cord was placed out of reach, hanging on the bedrail by the back of the bed, while the resident was laying in bed. The resident verified that they could not see or reach their call bell.

The resident required staff assistance for all aspects of their care, and not being able to see or access their call bell could have resulted in the resident not getting assistance when needed.

Sources: Resident's care plan; observations, interview with resident. [748]

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(c) the implementation of interventions to mitigate and manage those risks;

The licensee has failed to ensure a nutrition intervention for a resident was implemented.

Rationale and summary

Lunch service was observed in a dining room. Staff members served a resident food and fluids that did not meet the nutrition interventions that were in place for the resident.

The resident's plan of care provided the information and direction on how to implement the nutrition interventions.

The home's Registered Dietitian (RD) indicated that staff were supposed to follow the information in the resident's plan of care.

Failing to follow the resident's nutrition interventions could place the resident at nutritional risk.

Sources: resident's clinical records, interview with RD, observations. [740739]

WRITTEN NOTIFICATION: Menu planning

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (1) (e)
Menu planning
s. 77 (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(e) includes a choice of other available entrées and side dishes at all three meals and a choice of other desserts at lunch and dinner, to meet residents' specific needs

or food preferences;

The licensee has failed to have a menu in place that offered choice of menu option that met the needs of a resident.

Rationale and summary

Resident's clinical records indicated they required a texture modified diet.

The resident was observed at lunch in the dining room. They were served a menu item and were observed to not tolerate the menu item.

The home's Food Service Manager (FSM) indicated to inspector #740739 that according to their therapeutic menu, the menu item was appropriate for the resident's diet order.

According to progress notes, the resident was previously assessed by the home's RD with the same menu item. The RD documented the resident did not tolerate the menu item. The RD confirmed this in an interview with inspector #740739.

Failing to have a menu in place that accommodated the resident's dietary needs limited their choice at the meal and may impact quality of life.

Sources: resident's clinical records, therapeutic menu, recipe, interviews with RD and FSM, observations. [740739]

WRITTEN NOTIFICATION: Dining and snack service

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 79 (1) 7.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
7. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

The licensee has failed to ensure residents were served their meal course by course at lunch service.

Rationale and Summary

During lunch service staff were observed serving the dessert course to residents at three different tables, for a total of seven residents, before they had completed their entrees.

The home's policy for dining room meal service indicated that all meals will be served course by course.

Failing to serve meals course by course can negatively impact the resident's pleasurable dining experience.

Sources: observation, policy: dining room meal service protocol, dated January 2023. [740739]

WRITTEN NOTIFICATION: Maintenance services

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (a)

Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

The licensee has failed to ensure that procedures were implemented to ensure that the home's call bell system was kept in good repair.

Rationale and Summary
On a day in February, 2024, a resident identified that the call bell by their bed was not working. The inspector tested the call bell with a staff member at a specific time and the light on the console was not lighting up when the button was pressed.

The Administrator verified that if there were issues related to the call bell, staff would report the issue in the maintenance log, and if the issues continued, the call bell company would be contacted for further support.

Issues related to the call bell in the room were reported in the maintenance log in on two previous occasions. The actions to the issues were not clear however there was no other documentation related to the call bell not working in February 2024.

The Administrator checked the call bell report at the specific time and verified that there was no call initiated from the bedside call bell and confirmed that the call bell was not kept in good repair.

There was a risk that the resident, who relied on staff to assist them with all aspects of care, would not be able to call for assistance when needed.

Sources: Observations, resident's care plan, maintenance log, interview with resident, staff, and the Administrator. [748]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #012 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 staff followed additional precautions related to disposal of PPE.

Specifically, the IPAC Lead failed to ensure PPE, specifically disposable face shields, were disposed of following use, in accordance with the "Infection Prevention and Control Standard for Long-Term Care Homes, April 2022" (IPAC Standard) as required by Additional Requirement 9.1.

Rationale and summary

Observations of two identified home areas were made related to personal protective equipment for residents requiring droplet contact precautions. Signage on these resident doors indicated face shields were required when providing care. Caddies mounted on doors were not stocked with face shields.

A registered staff indicated to inspector #740739 that face shields were not stocked in the PPE caddies since staff had their own face shield that they disinfected and stored. The registered staff member indicated the face shields were reusable and staff were directed to disinfect with wipes between use. Three PSW's all confirmed this was their practice and they were not told the face shields were disposable.

Signage observed posted in the hallway of a home area indicated that disposable face shields must be discarded after one use.

When interviewed, the IPAC Lead indicated the face shields could be reused and disinfected and they were not disposable. Inspector #740739 and the IPAC Lead inspected the box the face shields were received in and the label on the box indicated "disposable face shield". The IPAC Lead later acknowledged the face shields were not reusable and staff should be disposing them after each use.

Failing to follow guidelines for use of disposable face shields may have impacted the efficacy of personal protective equipment.

Sources: interview with IPAC Lead and staff, record review PHO infographic, observation of face shields. [740739]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (11) (b)
Infection prevention and control program
s. 102 (11) The licensee shall ensure that there are in place,
(b) a written plan for responding to infectious disease outbreaks. O. Reg. 246/22, s.

102 (11).

The licensee has failed to ensure their outbreak management policy was implemented when a COVID-19 outbreak was declared.

In accordance with O Reg. 246/22 s. 11 (1) (b) the licensee is required to ensure there was a written plan for responding to infectious disease outbreaks and must be complied with.

Specifically, the IPAC Lead did not comply with the home's policy "Outbreak Management", dated October 2023 which was included in the licensee's Infection Prevention and Control Program.

Rationale and summary

The home submitted a Critical Incident Report that indicated a COVID-19 outbreak was declared in the home on a day in February, 2024.

The home's outbreak management policy indicated the IPAC Lead or delegate is to ensure signs are posted at entrances to the home to notify staff and visitors that the home is in outbreak.

Signs indicating the home was in outbreak were not observed to be posted at the entrances of the home until 14 days later.

In an interview with the IPAC Lead, they acknowledged outbreak signage should have been posted when the outbreak was declared.

Failing to post signs indicating the home is in outbreak did not communicate

outbreak status of home to staff or visitors.

Sources: policy: Outbreak Management, dated October 2023, observations, interview IPAC Lead. [740739]

WRITTEN NOTIFICATION: Security of drug supply

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 2.
Security of drug supply
s. 139. Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
2. Access to these areas shall be restricted to,
i. persons, other than personal support workers, who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.

The licensee has failed to ensure that steps were taken to ensure that the basement drug storage room's access was restricted to persons, other than personal support workers, who may dispense, prescribe or administer drugs in the home, and the Administrator.

Rationale and Summary
During an observation on a day in February, 2024, it was identified that a maintenance staff was able to access the drug storage room in the basement.

The DOC verified that maintenance staff should not be able to access the drug storage room in the basement.

There was a risk to the security of drug supply when the access to the basement drug storage room was not restricted to persons, other than personal support workers, who may dispense, prescribe or administer drugs in the home, and the Administrator

Sources: Observation; interview with the DOC. [748]

WRITTEN NOTIFICATION: Additional training — direct care staff

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 1.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.

The licensee has failed to ensure that all direct care staff received annual training in all areas required under subsection 82 (7) of the Act.

1) Falls prevention and management.

Rationale and summary

A review of training records for 2023 indicated that 90.7% of direct care staff completed their annual falls prevention and management training that year.

The Administrator confirmed this and indicated that not all direct care staff completed their training in 2023.

As a result, there was risk that residents may not receive the most up-to-date and relevant care related to falls prevention and management.

Sources: record review of 2023 training records; interview with the Administrator. [740739]

WRITTEN NOTIFICATION: Additional training — direct care staff

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 2.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care.

The licensee has failed to ensure that all direct care staff received annual training in all areas required under subsection 82 (7) of the Act.

2) Skin and wound care

Rationale and summary

A review of training records for 2023 indicated that 90.9% of direct care staff completed their annual skin and wound care training that year.

The Administrator confirmed this and indicated that not all direct care staff completed their training in 2023.

As a result, there was risk that residents may not receive the most up-to-date and relevant care related to skin and wound care.

Sources: record review of 2023 training records; interview with the Administrator. [740739]

WRITTEN NOTIFICATION: Additional training — direct care staff

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 4.
Additional training — direct care staff
s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of pain.

The licensee has failed to ensure that all direct care staff received annual training in all areas required under subsection 82 (7) of the Act.

4) Pain management, including pain recognition of specific and non-specific signs of pain.

Rationale and summary

A review of training records for 2023 indicated that 91.5% of direct care staff completed their annual pain management training that year.

The Administrator confirmed this and indicated that not all direct care staff completed their training in 2023.

As a result, there was risk that residents may not receive the most up-to-date and relevant care related to pain management and recognition.

Sources: record review of 2023 training records; interview with the Administrator. [740739]