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 # / Registre no	Type of Inspection / Genre d'inspection
Jun 27, 2017	2017_632502_0007	029190-15, 002002-16, 004842-16, 010162-16, 011744-16, 014876-16, 015695-16, 024738-16, 030253-16, 032587-16, 033263-16, 034263-16, 001406-17, 002287-17, 007417-17, 008215-17, 008732-17	Critical Incident System

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 Woodhaven Long Term Care Residence
380 Church Street MARKHAM ON L6B 1E1

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

JULIENNE NGONLOGA (502), ANGIE KING (644), FAYLYN KERR-STEWART (664), STELLA NG (507)

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): April 25, 26, 27, 28, May 1, 2, 4, 5, 8, 9, 10, 11, 12, 15, 16, 17, 18, and 19, 2017.

The following intakes were completed during this inspection:
#010162-16, #024738-16, #014876-16, #030253-16, #032587-16, #002287-17, #007417-17, #008215-17, related to alleged staff to resident abuse;
#029190-15, #002002-16, #004842-16, #015695-16, related to alleged resident to resident abuse;
#011744-16, #033263-16, #034263-16, related to transferring and positioning;
#001406-17, related to injury with unknown cause;
#008732-17, related to minimizing of restraining.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Interim Director of Care (I-DOC), Resident Care Coordinator (RCC), Attending Physician, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator, Food Service Supervisor (FSS), Registered Dietitian (RD), Social Worker (SW), Physiotherapist (PT), Physiotherapist Assistant (PTA), Occupational Health Therapist (OT), Personal Care Providers (PCPs), Dietary Aide (DA), Residents, Family Members and Substitute Decision Makers.

During the course of the inspection, the inspectors conducted observation in home and residents' areas, observation of care delivery processes including toileting, transfer, and meal delivery services, and review of the home's staff training records, staff schedules, staff personal records, incidents investigation records, relevant policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

- **9 WN(s)**
- **5 VPC(s)**
- **1 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 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 use safe transferring and positioning devices or techniques when assisting residents.

A Critical Incident System Report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to improper and unsafe transfer.

Review of the CIS and progress notes revealed resident #026 reported to the home that on an identified date, he/she was improperly transferred by two staff resulting in pain.

Review of resident #026's medical history revealed specified health conditions. Review of resident #026's most recent Lift and Transfer Assessment, indicated the use of a Hoyer lift for transfers.

Review of resident #026's most recent Physiotherapy assessment indicated the resident was at high risk for falls. The Physiotherapy assessment further revealed that a mechanical ceiling/Hoyer lift was to be used for transfers and toileting of the resident.

Review of the most recent Resident Assessment Instrument-Minimum Data Set (RAI-MDS) quarterly assessment for resident #026 revealed he/she was total dependent for transfers by two staff with a mechanical lift.

Review of resident #026's most recent written plan of care revealed that the resident was to be provided total assistance by two staff members using a mechanical Hoyer lift for transfers and toileting.

Review of the home's investigation notes of the incident revealed staff #133 had told the physiotherapist (PT) that he/she had transferred resident #026 onto the toilet using the sit to stand mechanical lift.

Staff #133 and #157 told the inspector during interviews that they had transferred

resident #026 from the wheelchair to the toilet using the sit to stand lift. Staff #133 further stated that the resident refused to use the Hoyer lift, as he/she preferred the sit to stand lift for toileting.

Registered Practical Nurse (RPN) #163 in an interview stated that the PCPs did not provide a safe transfer to resident #026 when they used the sit to stand lift to transfer the resident to the toilet.

Staff #123 in an interview confirmed that staff #133 and #157 did not provide safe transfer to resident #026 as both staff used a sit-to-stand lift when resident #026 was not able to weight bear. [s. 36.]

2. A CIS was submitted to the MOHLTC related to improper transfer that caused resident #002 to sustain a fall with injury.

Review of the CIS and progress notes revealed that on an identified date and time, resident #002 had a fall while staff #130 and #116 attempted to provide a specified care using a specific sized hygiene sling and a mechanical Hoyer lift. The CIS and the progress notes further revealed that resident #002 leaned to the side, slid out of the sling, fell and sustained injury.

Review of Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment with an identified date, revealed resident #002 had specified medical condition. Further review revealed that resident #002's was at high risks of falls. There was no Lift and Transfer assessment completed on resident #002 prior to the above identified incident. The most recent Lift and Transfer assessment was completed after the incident.

Review of resident #002's written plan of care with an identified date, revealed resident #002 was supposed to be provided total assistance with two staff members using a mechanical Hoyer lift with a specific sized sling for all transfers.

On an identified date and time, the inspector observed resident #002 being transferred from bed to chair by staff #125 and #126 using a different sized sling then that identified in the plan of care.

Staff #125 acknowledged that resident #002 required a specific sized sling for transfer. The staff confirmed using a different sized sling because the specified size was not available on the unit. Staff #125 stated that he/she should have informed the charge

nurse and requested a new sling.

Staff #126 acknowledged that resident #002 required a specific sized for transfer, but did not check to ensure the proper size for the resident was used, as he/she was relying on staff #125.

Staff #130 in an interview stated that on identified date, he/she and staff #116 used a specific sized with a mechanical Hoyer lift for resident #002. As soon as the lift was away from the bed, resident #002 leaned over on one side and fell out of the sling. PCP #130 did not remember the type of sling used during the transfer.

The home uses different types of slings including toilet sling. According to Tollos Incorporate. Sling Guide, the toilet sling also called hygiene sling is used to toilet residents, who are able to support their heads and necks, cognitive and able to follow commands. This type of sling is only used with a sit to stand mechanical lift.

Staff #116 denied using the hygiene sling during the transfer, which contradict staff #129 statement that he/she was called to assess resident #002 after the fall occurred and noted hygiene sling beside the resident. The RPN stated that the hygiene sling used by the staff only supported the arm and the legs, making it easy for resident #002 to slide out of the sling. He/she stated that staff should have used a full sling for the resident’s safety.

Staff #123 in an interview confirmed that the hygiene sling and the mechanical Hoyer lift were used for resident #002's transfer. The staff told the inspector that all direct care staff had been trained by a representative from Tollos Incorporate to use hygiene sling only with the sit-to-stand lift. He/she stated that the staff should have obtained a specific sized full sling when using the mechanical Hoyer lift for transfer. As result staff failed to use safe transferring devices when assisting resident #002.

The severity of this incident is actual harm/risk as the resident sustained an injury. The scope of this incident is isolated to one resident. The previous compliance history revealed ongoing non-compliance with VPC. As a result of this non-compliance with O. Reg. 79/10, s. 36, a compliance order is warranted. [s. 36.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. 2007, c. 8, s. 6 (5).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

A CIS report was submitted to the MOHLTC in relation to an alleged abuse from staff that

caused resident #020 sustained an injury.

Review of resident #020's RAI-MDS with an identified date, revealed the resident exhibited responsive behaviours . Record review of resident #020's Documentation Survey Report (DSR) in relation to behaviour monitoring for identified months, revealed that the resident exhibited responsive behaviours over a specified period of time.

Staff #115, #116, #117, #161, and #121 in interviews revealed that resident #020 would refuse care from staff whom he/she was not familiar with, but was cooperative with staff he/she was familiar with provided care.

Record review of resident #020's care plan on an identified date, failed to reveal a focus, goal and interventions for the resident's identified behaviours.

Interviews with staff #121 and #123 revealed that staff were aware of resident #020's history of the above identified behaviours. Staff #123 confirmed that interventions for resident #020's identified behaviours should be developed and included in the resident's written plan of care. [s. 6. (1) (a)]

2. A CIS was submitted to the MOHLTC related to improper care and alleged neglect of resident #016 by staff. Review of the CIS revealed that on an identified date, resident #016 was not cared for adequately by staff #151, as evidence by he/she remained incontinent during a specific time.

Staff #158 and #155 stated that at they found resident #016 incontinent in bed and had not received care. Staff #152, #158, #140 and #155 in interviews stated that resident #016 should not be left in a specified position in bed to address resident's responsive behaviour. Staff #140 further stated that staff had been directed on interventions to prevent the above mentioned behaviour. He/she confirmed that intervention had not been included in resident #016's written plan of care.

In an interview Staff #151 acknowledged being aware of the resident's responsive behaviour, but confirmed not complying with the above mentioned interventions.

Review of the resident's written plan of care failed to reveal interventions for the resident's responsive behaviour.

Staff #123 acknowledged that resident #015's above mentioned interventions for the

resident’s behaviour should be included in the plan of care. [s. 6. (1) (a)]

3. A CIS was submitted to the MOHLTC related to alleged resident-to-resident abuse.

Review of the CIS revealed on an identified date and time, resident #011 was observed abusing resident #013. Review of resident #011's RAI-MDS admission assessment, and quarterly assessments completed on an identified dates, revealed that the resident exhibited responsive behaviours. Review of resident #011's care conference revealed that a specified responsive behavior was raised as a concern during the six-week post admission care conference.

Review of resident #011's plan of care failed to reveal a focus, goal and interventions for the resident’s identified responsive behaviours.

Interview with staff#140 and #146 stated that the identified responsive behaviours were not included in resident #011’s initial plan of care as well as the three-month revised written plan of care, and they confirmed that those should have been included in the written plan of care. [s. 6. (1) (a)]

4. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

A CIS was submitted to the MOHLTC related to an alleged abuse from staff that caused resident #020 to sustain an altered skin integrity.

Review of the CIS report and progress notes of resident #020 revealed that on an identified date, resident was found with an altered skin integrity. The resident was not able to provide information on how he/she obtained the altered skin integrity. The home initiated an investigation, notified the family, the police and the MOHLTC.

Interview with staff #153 revealed that he/she observed and reported the noted altered skin integrity to staff #145.

Record review of resident #020’s progress notes failed to reveal the above mentioned altered skin integrity.

Interview with staff #145 revealed that on an identified date, he/she assessed resident #020's altered skin integrity after receiving a report from the evening PCP. Staff #145 stated that he/she did not document the outcome of the assessment. Staff #145 further stated he/she did not communicate the altered skin integrity to the oncoming shift.

Interview with staff #172 revealed that when altered skin integrity are observed on a resident, the Home's expectation is to document the assessment on Point Click Care (PCC), notify the family and discuss the observation in the daily nursing meeting. Staff #172 further revealed that the home initiated the investigation when another staff noted the altered skin integrity. Staff #172 confirmed that staff #145 did not follow the home's protocol when he/she failed to collaborate with the team in developing resident #020's plan of care related to the above mentioned altered skin integrity. [s. 6. (4) (b)]

5. The licensee has failed to 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.

A CIS was submitted to the MOHLTC related to an alleged abuse from staff that caused resident #020 to altered skin integrity on an identified body part.

Review of the CIS report and progress notes of resident #020 revealed that on an identified date, resident was found with an altered skin integrity. The resident was not able to provide information on how he/she obtained the skin integrity changes. The home initiated an investigation, and notified the family, identified agencies and MOHLTC.

Interview with staff #153 revealed that he/she observed and reported altered skin integrity on resident #020 to staff #145.

Interview with staff #145 revealed that on an identified date, he/she assessed resident #020's altered skin integrity after receiving a report from the evening PCP. Staff #145 stated that he/she did not notify the family of the observed altered skin integrity. Staff #145 further stated that he/she did not endorse the observation to the oncoming shift staff to notify the family.

Interview with staff #172 revealed that when altered skin integrity is observed on a resident, the home's expectation was to document the assessment on Point Click Care (PCC), notify the family and discuss the observation in the daily nursing meeting. Staff

#172 confirmed that staff #145 did not follow the home's protocol in regards to notifying family and providing the family an opportunity to participate in developing resident #020's plan of care related to the altered skin integrity. [s. 6. (5)]

6. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A CIS was submitted to the MOHLTC related to alleged physical abuse from staff to resident. .

On a specified date the inspector observed the afternoon snack service on a specified floor. The inspector observed staff #102 assisting resident #001 with a snack without a specified eating device.

Review of resident #001's current written plan of care revealed that the resident required specified assistive devices due to resident #001's specified medical condition.

Inspector approached staff #102 with the written plan of care and inquired what the resident's dietary requirement was. Staff #102 was unaware of the resident feeding needs He/she continued to assist the resident without the specific assistive device although it was available and indicated in resident #001's written plan of care.

This was brought to staff #103's attention that was present on the unit. Staff #103 stated that the resident required the specific assistive devices to meet the nutritional requirements. He/she proceed to inform the staff member. Staff #102 stated that he/she had not used the specific assistive devices and would use it the next time. [s. 6. (7)]

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
- there is a written plan of care for each resident that sets out the planned care for the resident,
- the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.
- 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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are protected from abuse by anyone and that residents are not neglected by the licensee or staff.

A CIS was submitted to the MOHLTC related to improper care and alleged neglect of residents #015 and #016 by a staff member. Review of the CIS revealed that on an identified date, residents #015 and #016 were not cared for adequately by staff #151, as evidenced by both residents had remained incontinent for a period of time.

1. Review of the RAI-MDS assessment completed on admission, revealed that resident #015 was frequently incontinent.

Review of the written plan of care revealed that resident #015 required extensive assistance with a specified care and wore incontinent products.

Review of the progress notes revealed that at the beginning of the identified shift staff #159 had asked staff #155 to assess resident #015, as the resident was noted with signs of incontinence. Further review of the progress notes revealed that after an identified meal resident #015 was transferred to bed and his/her incontinence product was changed at that time.

Review of the electronic medication administration record (eMAR) for an identified month, revealed that resident #015 was given a specified scheduled medication. Review of Documentation Survey Report (SDR) for the same month, revealed that resident #015 had been incontinent multiple times in an identified period of time.

The following was revealed during staff interviews:
Staff #159 stated that while he/she was doing rounds at the end of an identified shift, he/she noted that resident #015 was in bed and had been incontinent. Resident #015 was calling for assistance with care. Staff #159 called staff #155 to report resident was incontinent and was not provided care by the previous shift.

Staff #151 stated that after he/she had transferred resident #015 to bed at a identified time and changed his/her incontinence product. The staff completed rounds before the end of the shift, and was not required to check whether resident #015 was soiled, as resident was capable of asking for assistance with care. This contradicts staff #123 statement that during rounds, staff should ensure the safety of the residents and check if the residents' continent products need to be changed.

Staff #155 stated that he/she was called by staff #159 to check on resident #015. The staff confirmed that he/she found resident #015 in bed fully incontinent. The resident was provided care and assessed the resident thereafter.

2. Review of the RAI-MDS assessment completed on admission, revealed that resident #016 had a severe impairment, was incontinent, used continent care products, and was to be provided total assistance with two staff members during care. Staff were directed to check and change resident #016 as per care schedule.

Review of the progress notes revealed that on an identified date at the beginning of the shift staff #158 had asked staff #155 to assess resident #016, as the resident was found incontinent and with no incontinent product. Further review of the progress notes revealed that staff #151 reported at the end of shift to staff #155 that resident #016 needed a specified medication.

Review of the eMAR for an identified month, revealed that resident #016 was given a specified scheduled medication. Review of the DSR for the same month month, revealed that resident #016 was incontinent on multiple times during an identified period of time.

Review of the home's investigation notes revealed that staff #151 had transferred resident #016 to bed and changed his/her incontinent product after an identified meal. While serving a specified meal staff #151 noted the resident had been incontinent and requested assistance from staff #152. Both staff care for resident #016. Staff #151 placed an incontinent product under the resident without securing it and left the resident, as the staff had not completed to provide care.

The following was revealed during staff interviews:
Staff #152 stated that at an identified time staff #151 checked on resident #016 and found that he/she was incontinent. Staff #152 went to help staff #151 as he/she had requested assistance. Once in the room, he/she noted that staff #151 had removed all the bed linen and had not replaced them, had removed the resident's soiled clothes and had positioned an incontinent care product under the resident, as both staff had not completed caring for resident #016. Staff #152 stated that staff #151 told him/her that he/she was in a rush and would endorse the care to the incoming shift. Both staff left resident #016 lying on the bed without bed linen or clothing, and with an incontinent care product under him/her. Staff #152 stated that he/she had informed staff #159, at the start of the shift, as resident #016's was assigned staff #158 and #159 told staff #152 that resident #016 was not part of his/her assignment. Staff #159 told the inspector that he/she did not recall resident #016's care being endorsed to him/her on the day of the alleged neglect.

Staff #151 stated that at the end of the shift he/she left the resident incontinent. Staff #151 stated he/she placed an incontinent care product under the resident and informed staff #155 that resident #016 needed a specified medication, which contradict the resident's specified care record that indicated multiple episodes of incontinence.

Staff #155 stated that he/she arrived on the unit five minutes prior to the start of shift, and met staff #151 at the nursing station. The staff told him/her that resident #016 required a specific medication and exited the unit. Staff #155 stated that he/she completed the narcotic count, shift report, and then checked the resident’s specific medication order. Staff #155 did not assess the resident at the beginning of shift as the documentation had indicated that resident #016 had a specified medication and therefore did not require it.

Staff #158 stated that while doing the rounds at the beginning of his/her shift, he/she noted that resident #016 was in bed without linen, the resident had not been provided incontinence care. Staff #158 called staff #155 to report resident was incontinent and was not provided care by the previous shift.

Staff #155 stated that on an identified time he/she was called by staff #158 to check on resident #016. The staff stated that he/she found resident #016 in bed without bed linen and undressed. The resident, the mattress, and the bed side rails were soiled. The resident was provided a shower and he/she assessed the resident thereafter.

Staff #160 stated that if a resident becomes incontinent at the end of a shift, staff should care for the resident or endorse the care to the incoming shift, to ensure the resident is cared for right away. Staff #160 confirmed that resident #015 was neglected by staff #160, as he/she left without informing anyone from the oncoming shift about the resident being incontinence and in need of care.

Staff #123 acknowledged that staff #151 had neglected resident #015, as he/she did not check whether the resident's incontinent care product needed to be changed, and failing to do so, he/she had left resident #015 incontinent for an extend period of time. The staff also acknowledged that resident #016 was neglected, as the resident was left incontinent for approximately one hour on an identified date. [s. 19. (1)]

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 residents are protected residents from abuse by anyone and that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all fluids are prepared, using methods which preserve taste, nutritive value, appearance and food quality.

Review of the Thickener Guideline for beverage preparation revealed that one table spoon (15 ml) of thickener powder is needed to thicken 125 ml cup of crystal juice to nectar consistency, and two tablespoons (30 ml) of thickener powder are needed to thicken 175 ml cup of coffee to nectar consistency.

On an identified date and time during an identified meal service, the inspector observed staff #102 prepare 125 ml cup of nectar thickened beverage by adding two teaspoons (10 ml) of Thickener powder for resident #001's beverage.

Review of resident #001's current written plan of care revealed that resident required an identified diet due specified medical condition.

On an identified date and time during an identified meal service, the inspector observed staff #154 prepare 175 ml cup of nectar thickened hot beverage by adding three teaspoons (15 ml) of thickener powder for resident #010's hot beverage.

Review of resident #010's written plan of care revealed that the resident required an identified diet related to identified medical condition.

Staff #154 in an interview stated being aware of the resident's diet and the need for specified thickened fluid. The RPN confirmed not following the recipe by adding three teaspoons (15ml) of thickener to thicken the resident's hot beverage, but denied that consistency was not appropriate for the resident.

Staff #103 in an interview confirmed that staff #102 and #154 had not prepared the above beverage according to recipe, as the above guideline provided measurement for different type of beverage and the quantity of Thickener Powder needed for each consistency. [s. 72. (3) (a)]

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 all fluids are prepared, using methods which preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (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. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that sufficient time is provided for residents to eat at their own pace.

A CIS was submitted to the MOHLTC related to an alleged abuse from staff in which resident #001 was provided inappropriate care.

Review of the CIS report revealed that on an identified date and time, during an identified meal service, staff #109 and #110 observed staff #108 provide care inappropriately to resident #001. Review of resident #001's recent plan of care revealed that he/she was at moderate nutritional risk with a specified, and required total assistance by one staff.

On an identified date, during meal service the inspector observed staff #104 providing specified care inappropriately to resident #001,.

Review of home policy titled Dining Room Meal Service Protocol #LTC-CA-WQ-300-03-02, revised February 2007, and Supporting a Culture of Best Practices in Resident Care under eating assistance revealed that staff will provide sufficient time for every resident to eat at his or her own pace, and staff are directed to encourage residents to eat slowly, ensuring food is thoroughly chewed prior to swallowing.

Staff #108 in an interview stated that he/she may have provided inappropriate identified care to resident #001 in order to get everything done on time, he/she stated that the home area had a high number of residents required assistance with the identified care and had limited time.

In an interview, staff #104 acknowledge that he/she had provided care inappropriately to the resident and had apologized.

Interview with staff #109 confirmed that on an identified date, staff #108 had provided care inappropriately to resident #001, and stated he/she did not intervene to stop staff #108.

Staff #110 stated that he/she was supervising the dining room and confirmed that staff #108 had provided inappropriately to the resident. The staff member also stated that he/she had met with staff #108 after the dining room service to caution staff #108 about feeding the resident at a fast pace. [s. 73. (1) 7.]

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 sufficient time is provided for residents to eat at their own pace, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff are provided training in falls prevention and management.

As a result of non-compliances under O. Reg. 79/10, s. 36 related to safe transferring and positioning devices or techniques when assisting residents, the home's 2016 staff education attendance records related to Falls Prevention and Management were reviewed.

Review of the 2016, staff education attendance records revealed that 44 per cent of direct care staff had not received training in Falls Prevention and Management.

In interviews, staff #131, #169 and #163 stated they had not completed training on falls prevention and management in 2016.

In an interview, staff #123 confirmed that 44 per cent of direct care staff had not received training on falls prevention and management in 2016. [s. 221. (2) 1.]

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 direct care staff are provided training in falls prevention and management, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The license has failed to ensure that the result of every investigation undertaken under clause (1) (a) of s. 23 of the LTCHA is reported to the Director.

A CIS was submitted to the MOHLTC in which resident #023's Substitute Decision Maker (SDM) had concerns of improper care related to transfers.

Review of the home's investigation notes, and interviews with resident #023's SDM and staff #123 revealed that investigation on the above mentioned alleged improper care was completed and unfounded.

Review of the above CIS report failed to reveal the outcome of the investigation.

Interview with staff #123 confirmed that the outcome of the investigation of the above mentioned alleged improper care was not reported to the Director as required under the Act. [s. 23. (2)]

2. A CIS was submitted to the MOHLTC in which resident #014 sustained alteration in skin integrity with unknown cause.

Review of the home's investigation notes and interview with staff #123 revealed that investigation on the alteration in skin integrity was completed and the cause was unknown.

Review of the CIS failed to reveal the outcome of the investigation.

Interview with staff #123 confirmed that the outcome of the investigation of the above mentioned injuries with unknown cause was not reported to the Director as required under the Act. [s. 23. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the report to the Director included the outcome or current status of the individual or individuals who were involved in the incident.

Review of a CIS report submitted to the MOHLTC on an identified date, revealed the Central Intake Assessment and Triage team (CIATT) requested an amendment of the CIS report to include the progress and outcome of the investigation and any actions taken by the outside agency.

In an interview, staff #119 confirmed that the above mentioned CIS report had not been amended as per the request of the Director. [s. 104. (1) 3.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 215. Criminal reference check

Specifically failed to comply with the following:

s. 215. (1) This section applies where a criminal reference check is required before a licensee hires a staff member or accepts a volunteer as set out in subsection 75 (2) of the Act. O. Reg. 79/10, s. 215 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that criminal reference checks were conducted within six months before a staff member was hired.

Related to findings of non-compliance related to O. Reg. 79/10, s. 19 (1) during this inspection, five staff personnel files were reviewed.

Review of the personnel file for staff #171 revealed that he/she had been hired at the long term care home on an identified date. The personnel file further revealed that a criminal reference check had been completed on an identified date, which was ten months prior to the hiring date.

Review of staff schedules from an identified period of time, revealed that staff #171 had worked a total of 40 shifts from his/her date of hire where he/she had provided care to residents.

In an interview, staff #171 stated the criminal reference check on file was the only one he/she had provided to the home.

In an interview, staff #123 confirmed that a criminal reference check had not been conducted within six months of hire for PCP #171. [s. 215. (1)]

Issued on this 20th day of July, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIENNE NGONLOGA (502), ANGIE KING (644), FAYLYN KERR-STEWART (664), STELLA NG (507)
Inspection No. / No de l'inspection :	2017_632502_0007
Log No. / Registre no:	029190-15, 002002-16, 004842-16, 010162-16, 011744-16, 014876-16, 015695-16, 024738-16, 030253-16, 032587-16, 033263-16, 034263-16, 001406-17, 002287-17, 007417-17, 008215-17, 008732-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 27, 2017
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
LTC Home / Foyer de SLD :	Chartwell Woodhaven Long Term Care Residence 380 Church Street, MARKHAM, ON, L6B-1E1
	Jason Gay

Name of Administrator /
Nom de l'administratrice
ou de l'administrateur :

To Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that staff use safe transferring and positioning devices or techniques when assisting residents with transfers, including but not limited to the following:
1) Ensuring all residents requiring mechanical lifts have the proper lift sling employed.
2) Ensure all staff use the correct lift and sling as assessed for each resident requiring mechanical lift transfers.
3) Implement an auditing system to ensure staff adherence with safe lifting and transferring techniques when assisting residents.

Please submit the plan to Juliene.ngonloga@ontario.ca no later than July 7, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A CIS was submitted to the MOHLTC related to improper transfer that caused resident #002 to sustain a fall with injury.

Review of the CIS and progress notes revealed that on an identified date and time, resident #002 had a fall while staff #130 and #116 attempted to provide a specified care using a specific sized hygiene sling and a mechanical Hoyer lift. The CIS and the progress notes further revealed that resident #002 leaned to the side, slid out of the sling, fell and sustained injury.

Review of Resident Assessment Instrument - Minimum Data Set (RAI-MDS)

assessment with an identified date, revealed resident #002 had specified medical condition. Further review revealed that resident #002's was at high risks of falls. There was no Lift and Transfer assessment completed on resident #002 prior to the above identified incident. The most recent Lift and Transfer assessment was completed after the incident.

Review of resident #002's written plan of care with an identified date, revealed resident #002 was supposed to be provided total assistance with two staff members using a mechanical Hoyer lift with a specific sized sling for all transfers.

On an identified date and time, the inspector observed resident #002 being transferred from bed to chair by staff #125 and #126 using a different sized sling then that identified in the plan of care.

Staff #125 acknowledged that resident #002 required a specific sized sling for transfer. The staff confirmed using a different sized sling because the specified size was not available on the unit. Staff #125 stated that he/she should have informed the charge nurse and requested a new sling.

Staff #126 acknowledged that resident #002 required a specific sized for transfer, but did not check to ensure the proper size for the resident was used, as he/she was relying on staff #125.

Staff #130 in an interview stated that on identified date, he/she and staff #116 used a specific sized with a mechanical Hoyer lift for resident #002. As soon as the lift was away from the bed, resident #002 leaned over on one side and fell out of the sling. PCP #130 did not remember the type of sling used during the transfer.

The home uses different types of slings including toilet sling. According to Tollos Incorporate. Sling Guide, the toilet sling also called hygiene sling is used to toilet residents, who are able to support their heads and necks, cognitive and able to follow commands. This type of sling is only used with a sit to stand mechanical lift.

Staff #116 denied using the hygiene sling during the transfer, which contradict staff #129 statement that he/she was called to assess resident #002 after the fall occurred and noted hygiene sling beside the resident. The RPN stated that the

hygiene sling used by the staff only supported the arm and the legs, making it easy for resident #002 to slide out of the sling. He/she stated that staff should have used a full sling for the resident's safety.

Staff #123 in an interview confirmed that the hygiene sling and the mechanical Hoyer lift were used for resident #002's transfer. The staff told the inspector that all direct care staff had been trained by a representative from Tollos Incorporate to use hygiene sling only with the sit-to-stand lift. He/she stated that the staff should have obtained a specific sized full sling when using the mechanical Hoyer lift for transfer. As result staff failed to use safe transferring devices when assisting resident #002. (502)

2. Critical Incident System Report (CIS) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to improper and unsafe transfer.

Review of the CIS and progress notes revealed resident #026 reported to the home that on an identified date, he/she was improperly transferred by two staff resulting in pain.

Review of resident #026's medical history revealed specified health conditions. Review of resident #026's most recent Lift and Transfer Assessment, indicated the use of a Hoyer lift for transfers.

Review of resident #026's most recent Physiotherapy assessment indicated the resident was at high risk for falls. The Physiotherapy assessment further revealed that a mechanical ceiling/Hoyer lift was to be used for transfers and toileting of the resident.

Review of the most recent Resident Assessment Instrument-Minimum Data Set (RAI-MDS) quarterly assessment for resident #026 revealed he/she was total dependent for transfers by two staff with a mechanical lift.

Review of resident #026's most recent written plan of care revealed that the resident was to be provided total assistance by two staff members using a mechanical Hoyer lift for transfers and toileting.

Review of the home's investigation notes of the incident revealed staff #133 had told the physiotherapist (PT) that he/she had transferred resident #026 onto the toilet using the sit to stand mechanical lift.

Staff #133 and #157 told the inspector during interviews that they had transferred resident #026 from the wheelchair to the toilet using the sit to stand lift. Staff #133 further stated that the resident refused to use the Hoyer lift, as he/she preferred the sit to stand lift for toileting.

Registered Practical Nurse (RPN) #163 in an interview stated that the PCPs did not provide a safe transfer to resident #026 when they used the sit to stand lift to transfer the resident to the toilet.

Staff #123 in an interview confirmed that staff #133 and #157 did not provide safe transfer to resident #026 as both staff used a sit-to-stand lift when resident #026 was not able to weight bear.

The severity of this incident is actual harm/risk as the resident sustained an injury. The scope of this incident is isolated to two residents. The previous compliance history revealed ongoing non-compliance with VPC. As a result of this non-compliance with O. Reg. 79/10, s. 36, a compliance order is warranted. (644)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 27th day of June, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julienne NgoNloga

Service Area Office /
Bureau régional de services : Toronto Service Area Office