Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 18, 2019	2019_810654_0004	005319-18, 007338-19, 007727-19	Complaint

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

SIMAR KAUR (654), JULIEANN HING (649)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 27, 28, 29, 30, and September 04, 05, 06, 09, 10, 11, 12, 13, 16 and 17, 19 (off- site inspection), 2019.

The following complaint intakes were inspected during this complaint Inspection:
Log #005319-18- was related to alleged neglect and abuse, and fall prevention interventions.
Log #007338-19 and log# 007727-19- were related to alleged abuse, responsive behaviours, and resident bill of rights.

PLEASE NOTE: A Written Notification and Volunteer Plan of Correction related to LTCHA, 2007, s. 6. (7), 6 (10) (b), was identified in this inspection and has been issued in inspection report 2019_810654_0005, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator, Personal Care Provider (PCP), Registered Nurse (RN), Resident Care Coordinator (RCC), Registered Practical Nurse (RPN), Physiotherapist (PT), Residents, and Resident's Substitute Decision Maker (SDM).

During the course of the inspection, the inspector made observations related to the home's care processes; staff to resident, and resident to resident interactions; conducted record reviews and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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

7 WN(s)
4 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	Légende 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. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incidence of falls and the risk of injury for residents #007, #008, #015, #016, #017, #018, #019, #020, #022, #023, #024, #025, #026, #027, and #028.

An anonymous complaint was submitted to the Ministry of Long-Term Care (MLTC), related to concerns with the implementation of falls prevention and management interventions.

(A) During an observation on an identified date and time, with RPN #112 and with PSW on an identified resident home area, residents #007 and #008 were observed at two different identified times and did not have an identified falls prevention and management equipment in place.

Resident #007’s plan of care under the falls focus indicated that the resident was at a medium risk for falls and required the above specified falls prevention and management equipment.

Resident #008’s care plan under the falls focus indicated that the resident was at a high

risk for falls and to ensure that the above specified falls prevention and management equipment was in use.

In an interview with PCP #137, they acknowledged that resident #007 was observed and did not have the above specified falls prevention and management equipment on the above identified date and told the inspector that the resident usually did. With regards to resident #008, PCP #137 acknowledged that the resident did not have the above specified falls prevention and management equipment in place and explained that the resident usually did not have the equipment in place.

In an interview with RAI- MDS coordinator #138, they told the inspector that residents #007 and #008 were required to have their above specified falls prevention and management equipment at all times.

In an interview with ADOC #133 they explained that staff should have followed the plan of care and kardex for their falls prevention interventions, and residents #007 and #008 should have had their above specified falls prevention and management equipment at all times.

2. During observation on an identified date and time, with PCP #115 and RPN #114 on an identified resident home area, the following observations were made by inspector #654 and were confirmed by the PCP and RPN at the same time.

(A) Residents #015, #016, #017, #018, and #019 were observed on the above identified date and they did not have identified falls prevention and management equipment in place.

-Record review of resident #015, #018, and #019's plan of care indicated that they were at high risk for falls.
-Record review of resident #016 and #017's plan of care indicated that they were at low risk for falls. All above mentioned residents falls prevention interventions identified that staff should ensure the use of specified falls prevention and management equipment as a safety device.

Interview with PCP #116 indicated that PCPs during a specified shift were responsible to ensure that the residents have their falls prevention and management equipment in place. Staff working on another specified shift were responsible to ensure the same. The

PCP further indicated that they had seen resident #016 with the above specified falls prevention and management equipment one to two times in the last year. They had also worked with residents # 017, #018 and #019 on the identified shift on another identified date, and the residents did not use the above specified falls prevention and management equipment. The PCP indicated that they did not check the above mentioned residents to ensure that they had the equipment on the above mentioned date, when they started their shift.

Interview with RPN #114 indicated that the above mentioned residents were required to use the above specified falls prevention and management equipment during the above identified shift due to their fall risk on the above identified date.

(B) Residents #018, #020, #022, and #023 were observed on an identified date and time and they did not have an identified falls prevention and management equipment in place.

Record review of residents #018, #020, #022, and #023's plan of care indicated that they were at high risk for falls. Their falls prevention interventions identified that staff should ensure the use of above specified falls prevention and management equipment as a safety device.

Record review of resident #018, #022's Electronic Medication Administration Record (eMAR) for an identified month, indicated for registered staff to remind the PCP to check if the above specified falls prevention and management equipment was in use for the residents at three specified times. Further review of the eMAR identified that it was signed by RPN #114 on the above identified date.

Interview with RPN #114 indicated that they did not remind the PCP on the above identified date to check the above specified falls prevention and management equipment for resident #018, and #022, but had signed on their eMAR to indicate that they were in use.

In a separate interview with RPN #114 and PCP #115 indicated that residents #018, #022, and #023's above specified equipment was not in use on the above identified date. The RPN also indicated that resident #020 did not have the equipment for the last two months. RPN #114 and PCP #115 indicated that residents #018, #020, #022, and #023 did not have the above specified falls prevention and management equipment on the above identified date.

(C) Residents #019, #024, #025, #026, #027, and #028 were observed on an identified date and time and did not have an identified communication device accessible to them.

-Resident #026 and #028’s above specified communication devices were observed tied to two different specified areas and were not accessible to the residents.
-Resident #019, #024, #025, #027's above specified communication devices were observed hanging on the floor and were not accessible to the residents.

Record review of resident #019, #024, #026, #027,and #028's, plan of care indicated they were at moderate to high risk for falls. Resident #025’s was identified at a low risk for fall.

Resident #024, #025, #026, #027’s falls prevention intervention indicated for staff to ensure the above specified communication devices were clipped to their clothing. For residents #019 and #028 the interventions indicated that the specified communication device should be within their reach at all times.

Interview with RPN #114 indicated that residents #026 and #028, were able to use the specified communication device for assistance. They further indicated the night PCP and registered staff both were responsible to ensure that residents above specified communication devices were within their reach. Residents #019, #024, #025, #026, #027, and #028 should have had the above specified communication device within reach or clipped to their clothing.

Interview with PCP #116 indicated that they did not check if the above mentioned residents had the above specified communication device within reach or clipped to their clothing on the above identified date, during an identified shift.

Review of the home’s policy on Resident s Falls Prevention Program (LTC-CA-WQ-200-07-08), Last revised on June 2019, Appendix #4, indicated two above specified specified equipment are used by the home as part of their falls prevention and injury reduction strategies. Appendix #1 of the policy indicated under universal fall precautions implemented by the home that the above specified communication device should be within reach of the residents.

Interview with RAI-MDS coordinator #138 identified that as per the home's falls prevention program, two above specified equipment were used as specific strategies for the residents, to mitigate their fall risk. They further explained that under the universal fall

precautions implemented by the home, the above specified communication device should be clipped to the residents clothing or within their reach. They further reviewed resident #015, #016, #017, #018, #019, #020, #022, #023, #024, #025, #026, #027, and #028’s records and indicated that they were required to have fall prevention interventions implemented as identified in their plan of care on the above identified date.

Interview with physiotherapist #136 indicated that residents #015, #016, #017, #018, #019, #020, #022, #023, #024, #025, #026, #027, and #028 used the above specified falls prevention and management equipment as preventative measures to mitigate their fall risk and should be used at all times.

Interview with ADOC #133 indicated that the above specified equipment were interventions used by the home for the falls prevention and management program. They further acknowledged that the specified falls prevention interventions were not implemented for the above mentioned residents.

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. 3. Residents’ Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #017and #029's right not to be neglected by the licensee or staff was fully respected and promoted.

An anonymous complaint was submitted to the MLTC, related to an allegation of neglect of residents in the home.

During an observation on an identified date and time with PCP #115 and RPN #114, on an identified resident home area, resident #017 and #029’s incontinence products were observed wet. Moisture was observed leaking outside the incontinence products of both residents. Both staff members then proceeded to change the incontinence products of the residents.

Record review of both resident's RAI- MDS assessment, indicated that they were incontinent of bowel and bladder, and required incontinence products.

Interview with PCP #115 indicated that both residents' bed linens were found damp as their incontinence products were soaked with urine and the moisture had leaked out of the products. Interviews with the RPN #114 and PCP #115 confirmed that both residents' incontinence products were wet on the identified date, and they should have been changed earlier.

During a second interview with PCP #115, they indicated that they worked with PCP #116 on the opposite unit on the same identified resident home area on the above identified date. PCP #115 indicated that they found residents #017 and #029 soaking wet once in the last two months when PCP #116 was on break. PCP #115 further indicated that they had covered the unit during PCP #116’s break and found other unidentified residents continence products, bed linens and soaker pads wet on the unit.

In an initial Interview with PCP #116, who worked with both residents on the above identified date, they indicated that they start their first round to check and change residents’ incontinence products at an identified time on the identified shift. They did not check resident #017and #029 s incontinence product during their first round at the above identified time on the above identified date. They did not want to wake resident #017 and did not check resident #029, as they were called by another resident on the unit.

During a second interview with PCP #116, they indicated that they had changed resident #029 during the first continence care round. However, did not change resident #017 on the above identified date. PCP #116 further indicated that they do not call another PCP or RPN to assist with providing continence care for residents who require assistance by a specified number of staff during an identified shift as they are usually busy with their own work.

Interview with RPN #114 indicated that PCP #116 did not go into each residents’ room to check and change their incontinence products on the above identified date during an

identified time period on the above identified resident home area. The RPN further indicated that PCP #152 complained of finding residents with wet incontinence products and linens at the beginning of another identified shift.

During an Interview with PCP #152, they denied any incidents of finding residents wet at the beginning of the above identified shift on the above identified resident home area.

In separate interviews with RCC #122 and ADOC #133, they indicated that the PCP was required to check and change the incontinence products of residents #017 and #029 at their first care round. They further acknowledged that both residents’ continence care needs were neglected by PCP #116.

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 resident’s right not to be neglected by the licensee or staff is fully respected and promoted, to be implemented voluntarily.

WN #3: 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects

of care collaborated with each other in the assessment of residents #006, #016, and #017 so that their assessments were integrated and were consistent with and complemented each other.

A complaint was submitted to the MLTC, alleging that they had asked the home not to administer an identified medication to resident #006 but the resident had continued to receive the medication.

Record review of a progress note of an identified date, indicated that resident #006’s substitute decision maker (SDM) had requested for RPN #131 to stop several of the resident's medications, specifically three identified medications. According to the progress note written by the RPN, they asked resident #006’s SDM if they could wait until an identified day to speak with the physician, and the SDM responded that they could not. The RCC was informed of the SDM’s request for follow up with the physician the following day.

A review of a progress note dated on another identified date, by RCC #128 indicated that they had spoken with resident #006’s SDM and reviewed the dose of the two above identified medications. The RCC spoke with the physician about the SDM’s request and indicated that two above identified medications were discussed and reviewed, and changes made were communicated to the SDM. According to the documentation there was no discussion of the third above identified medication with the physician.

According to a progress note identified on another date, it indicated that RPN #131 administered the third above identified medication to the resident at an identified time for an identified behaviour. The resident was sleepy and was redirected to their room and slept until another identified time. The resident’s SDM visited and questioned why the resident was asleep and expressed that they had not approved this medication. The RPN told the SDM that the above identified medication had been ordered a long time ago. This was one of the medications that the SDM stated they had requested on above identified date, with RPN #131 to have stopped.

Further record review indicated that resident #006 was administered the third above identified medication three times in an identified month, twice on an identified date and once on another identified date, after the resident's SDM had spoken with RPN #131 on the above identified date and requested to have this medication stopped.

In an interview with RPN #131, they reviewed their documentation regarding the

conversation they had with resident #006's SDM and acknowledged that the SDM requested to have the above identified medication stopped.

In an interview with RCC #128 they told the inspector that they had spoken with the physician about the third above identified medication and that it had never been used; it was a as needed (PRN) order. They stated it was the physician's decision and was not sure if the physician had missed it.

In an interview with physician #130 they told the inspector that they were told that the third identified medication had not been used but was not aware of the SDM’s request to discontinue this medication.

Given that the documentation made by RCC #128 did not indicate that they had communicated to the physician that the resident's SDM wished to discontinue the above identified medication, and the physician advising the inspector that they had not been informed of the SDM’s request to discontinue the identified medication, this indicates a lack of collaboration in the assessment of resident #006’s above identified medication.

2. An anonymous complaint was submitted to the MLTC, related to concerns with the implementation of falls prevention interventions.

During an observation on an identified date and time, residents #016 and #017 did not have an identified falls prevention and management intervention.

Record review of both residents' plan of care, under fall risk focus indicated that they were at low risk for falls. Their fall prevention interventions identified to have a specified falls prevention and management intervention in place.

Review of resident #016 and #017’s Scott Fall Risk Assessment indicated that they were at low risk for falls.

Review of resident #016’s most recent physiotherapist assessment, indicated that the resident was at high risk for fall as per their Tinetti Balance and Gait Score. The resident’s mobility was affected due to identified physical decline.

Review of resident #017’s most recent physiotherapist assessment, indicated that the resident was at high risk for fall as per their Tinetti Balance and Gait Score. The

resident's mobility was affected due to identified physical and cognitive decline.

During an interview with RPN #114 they indicated that resident #016 did not have the above identified falls prevention and management intervention for a long time. Resident #017 did not always have the above identified falls prevention and management intervention. The RPN indicated that they were not sure if both residents still required to have the above identified falls prevention and management intervention.

Interview with RAI-MDS coordinator #138 indicated that for both residents, plan of care, fall risk assessment, and physiotherapy assessment provided conflicting information to the staff. Their plan of care should have indicated the level of fall risk according to their physiotherapy assessment. They further indicated that the Scott Fall Risk Assessment was a new tool the home had started using since an identified month, and was not sure if registered staff were using it correctly.

Interview with Physiotherapist #136 indicated that both residents were at high fall risk due to their poor gait and mobility. However, both residents Scott Fall Risk Assessment and plan of care indicated that they were at low fall risk. They further indicated that registered staff were responsible to revise the residents plan of care after each physiotherapy assessment.

Interview with the ADOC indicated that physiotherapy assessments and notes were considered a part of residents' plan of care.

Interview with RAI- MDS coordinator #138, ADOC #133 and Physiotherapist #136 indicated that there was a discrepancy with the assessments to determine resident #016 and #017's fall risk. Both residents' assessments were not integrated, consistent with and did not complement each other.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with for resident #006.

A review of the home's policy #LTC-CA-WQ-100-05-02 Abuse Allegations and Follow-Up, with an effective date of July 2010 and revision dates of November 2015, March 2016, July 2016, stated abuse reporting is immediate and mandatory. All employees are required to, as a component of Chartwell's internal reporting structure to ensure safety for all, report immediately to their respective supervisor/ person in charge of the building when:

-An abuse is witnessed and/ or,
-An abuse is suspected and/ or,
-At anytime information or knowledge of an allegation of an abuse is received or learned from any person.

A complaint was submitted to the MLTC, related to an allegation that resident #006 was

abused on an identified date in an identified resident home area.

According to the complainant the resident was in the above specified resident home area and a co-resident approached resident #006 and told them that they had no education, went around without their mobility aide, and abused the resident.

According to resident #006's progress note dated on an identified date, documented by an identified RPN student it indicated that resident #006 alleged that they were abused by a co-resident.

The home was unable to validate the resident's allegation. The student was not in the home during this inspection.

Further record review indicated that a skin assessment was completed for resident #006 on an identified date, related to the above allegation. According to the home's process and expectation, a head to toe skin assessment should have been completed at the time of the allegation instead of two days later.

Resident #006 was not interviewable during the inspection due to cognitive decline.

In an interview with RPN #110, who was working on the day of resident #006's allegation, they told the inspector that there were no witnesses to the incident, and they could not recall if they had immediately reported the allegation to their RCC.

In an interview with RCC #128 who was working on an identified date, they told the inspector that they only became aware of resident #006's allegation two days after the above identified date, and was not aware of the allegation when it was documented.

The DOC who was involved in this incident was not available for an interview during this inspection.

In an interview with ADOC #133, they explained that any allegation of abuse has to be immediately reported by an RPN to their RCC who will follow up with the DOC. They acknowledged that they did not see any progress notes written on the above identified date, indicating who the RPN had reported this allegation to, and stated that the RPN should have reported this immediately.

Given that RCC #128 only became aware of resident #006's allegation of abuse two

days later, this indicates that the home's policy on immediate reporting of abuse was not followed.

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 the home's written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #5: 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. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of resident #006 by anyone that the licensee knows of, or that was reported to the licensee was immediately investigated.

A complaint was submitted to the MLTC, related to an allegation that resident #006 was abused on an identified date in an identified resident home area.

According to the complainant the resident was in the above specified resident home area and a co-resident approached resident #006 and told them that they had no education, went around without their mobility aide and abused the resident.

According to resident #006's progress notes, there was documentation, by an identified RPN student who was not in the home during this inspection that resident #006 alleged that they had been abused. The home was unable to validate the resident's allegation.

Further review indicated that the home had submitted a CIS report to the MLTC related to the above allegation on an identified date. It indicated the same incident took place on another identified date, when progress notes stated it was reported by the resident on a third identified date.

Resident #006 was not interviewable during the inspection due to cognitive decline.

In an interview with RPN #110 who was working on the day of the allegation told the inspector that there were no witnesses to the incident, and they could not recall if they had immediately reported this allegation to the RCC.

In an interview with RCC #128 who was working on above identified date, they told the inspector that they only became aware of this allegation two days after the incident documented date, and was not aware of the allegation when it was documented. No immediate investigation was initiated two days after the incident was documented, when RCC #128 became aware of the allegation and advised the DOC.

The DOC who was involved in this incident was not available for an interview during this inspection.

In an interview with the ADOC #133 they indicated that the above mentioned allegation was not immediately investigated but was unable to provide any further explanation as they were not there.

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 every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place, was complied with.

In accordance with O. Reg. 79/10, s.48 (1) 1 and in reference to O. Reg. s. 49 (1), the licensee was required to have a Falls Prevention and Management Program that provided for strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the licensee's falls policy "Resident Falls Prevention Program- #LTC-CA-WQ-200-07-08, revised June 2019, as part of their Falls Prevention and Management Program which indicated under reassessment section, that residents fall risk level will be reassessed (using the Scott Fall Risk Assessment), annually (with the MDS assessment).

Review of resident #029's assessments indicated that the resident did not have any fall risk assessment since an identified date in 2013.

During an interview with RCC #122, they provided the inspector with a fall risk assessment for the resident completed on the above identified date in 2013 and indicated that the resident did not have a fall risk assessment after the identified date. They further indicated that the resident should have had the assessment annually as per the home's falls prevention policy.

Interview with the ADOC indicated that the fall risk reassessment should be done annually for residents and the home did not comply with their falls prevention policy for resident #029. [s. 8. (1) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the drugs were administered to resident #006 in accordance with the directions for use specified by the prescriber.

A complaint was submitted to the MLTC, alleging that resident #006 developed an identified condition after they were transferred to an identified resident home area.

Record review indicated that resident #006 was transferred from one identified home area to another identified resident home area on an identified date.

Further record review below indicated that the physician’s orders had not been followed or correctly transcribed:

(i) According to progress notes on an identified date, resident #006 had an identified symptom. A review of the electronic medication review (e-MAR) indicated that the resident was administered an identified medication six times in an identified month. Further review of this record and physician medication review signed by the physician on an identified date, indicated to stop the order for the above identified medication after 24 hours, and if symptoms persist, to notify the physician. The physician’s order was not followed as the action specified in the order was not taken when the resident continued to have symptoms after 24 hours.

(ii) Further review of progress notes indicated on an identified date, resident #006 had two identified symptoms. According to the e-MAR the resident was given another identified medication five times on identified dates. Further review of this record and physician medication review signed by the physician on an identified date, indicated to stop the order for the above mentioned medication after 72 hours and if symptoms persist or if they develop another identified symptom to call the physician. The physician’s order was not followed as the action specified in the order was not taken when the resident continued to have symptoms after 72 hours.

In an interview with RCC #128 they acknowledged that the physician’s order had not been followed in the above scenarios. [s. 131. (2)]

Issued on this 13th day of November, 2019

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

Ministère de la Santé et des Soins de longue durée

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

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) :	SIMAR KAUR (654), JULIEANN HING (649)
Inspection No. / No de l'inspection :	2019_810654_0004
Log No. / No de registre :	005319-18, 007338-19, 007727-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 18, 2019
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
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Belisha Ke

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.
O. Reg. 79/10, s. 48 (1).

Order / Ordre :

The Licensee must be complaint with O. Reg. 79/10, s. 48 (1) of the LTCHA 2007.

Specifically, the licensee must:

1. Ensure that direct care staff on all shifts implement the falls prevention and management interventions for residents #007, #008, #015, #016, #017, #018, #019, #020, #022, #023, #024, #025, #026, #027, and #028 and all other residents who are at risk for falls in the home.

2. Provide training to all registered nursing staff and personal care providers on:

I. Implementing falls prevention and management interventions on all shifts for the residents who are determined to be at risk for falls, with the aim to reduce the incidence of falls and the risk of injury.

II. The importance for staff to follow the home’s policy on Resident’s Falls Prevention Program, and relevant guidance and instructions specified in individual resident’s care plan, specifically to falls prevention and injury reduction strategies, and universal fall precautions implemented by the home.

Maintain the related training records including attendance records, dates the training was provided, and who provided the training.

3. Conduct post-training evaluation for the staff to ensure comprehension of the training material and maintain the evaluation records.

4. Develop and implement an on-going auditing process to ensure that all staff on all shifts implement falls prevention and management interventions for the residents with the fall risk. The auditing process must include all shifts.

Maintain a written record of the auditing process including the frequency of the audits, who will be responsible for doing the audits and evaluation of the results. The written record must also include the date and location of the audit, resident's name, name of staff members audited, and name of the person completing the audit.

Grounds / Motifs :

1. The licensee has failed to ensure that there was an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incidence of falls and the risk of injury for residents #007, #008, #015, #016, #017, #018, #019, #020, #022, #023, #024, #025, #026, #027, and #028.

An anonymous complaint was submitted to the Ministry of Long-Term Care (MLTC), related to concerns with the implementation of falls prevention and management interventions.

(A) During an observation on an identified date and time, with RPN #112 and with PSW on an identified resident home area, residents #007 and #008 were observed at two different identified times and did not have an identified falls prevention and management equipment in place.

Resident #007's plan of care under the falls focus indicated that the resident was at a medium risk for falls and required the above specified falls prevention and management equipment.

Resident #008's care plan under the falls focus indicated that the resident was at a high risk for falls and to ensure that the above specified falls prevention and management equipment was in use.

In an interview with PCP #137, they acknowledged that resident #007 was observed and did not have the above specified falls prevention and management equipment on the above identified date and told the inspector that the resident usually did. With regards to resident #008, PCP #137 acknowledged that the resident did not have the above specified falls prevention and management equipment in place and explained that the resident usually did not have the equipment in place.

In an interview with RAI- MDS coordinator #138, they told the inspector that residents #007 and #008 were required to have their above specified falls prevention and management equipment at all times.

In an interview with ADOC #133 they explained that staff should have followed

the plan of care and kardex for their falls prevention interventions, and residents #007 and #008 should have had their above specified falls prevention and management equipment at all times.

(649)

2. During observation on an identified date and time, with PCP #115 and RPN #114 on an identified resident home area, the following observations were made by inspector #654 and were confirmed by the PCP and RPN at the same time.

(A) Residents #015, #016, #017, #018, and #019 were observed on the above identified date and they did not have identified falls prevention and management equipment in place.

-Record review of resident #015, #018, and #019’s plan of care indicated that they were at high risk for falls.
-Record review of resident #016 and #017’s plan of care indicated that they were at low risk for falls. All above mentioned residents falls prevention interventions identified that staff should ensure the use of specified falls prevention and management equipment as a safety device.

Interview with PCP #116 indicated that PCPs during a specified shift were responsible to ensure that the residents have their falls prevention and management equipment in place. Staff working on another specified shift were responsible to ensure the same. The PCP further indicated that they had seen resident #016 with the above specified falls prevention and management equipment one to two times in the last year. They had also worked with residents # 017, #018, and #019 on the identified shift on another identified date, and the residents did not use the above specified falls prevention and management equipment. The PCP indicated that they did not check the above mentioned residents to ensure that they had the equipment on the above mentioned date, when they started their shift.

Interview with RPN #114 indicated that the above mentioned residents were required to use the above specified falls prevention and management equipment during the above identified shift due to their fall risk on the above identified date.

(B) Residents #018, #020, #022, and #023 were observed on an identified date and time and they did not have an identified falls prevention and management equipment in place.

Record review of residents #018, #020, #022, and #023's plan of care indicated that they were at high risk for falls. Their falls prevention interventions identified that staff should ensure the use of above specified falls prevention and management equipment as a safety device.

Record review of resident #018, #022's Electronic Medication Administration Record (eMAR) for an identified month, indicated for registered staff to remind the PCP to check if the above specified falls prevention and management equipment was in use for the residents at three specified times. Further review of the eMAR identified that it was signed by RPN #114 on the above identified date.

Interview with RPN #114 indicated that they did not remind the PCP on the above identified date to check the above specified falls prevention and management equipment for resident #018, and #022, but had signed on their eMAR to indicate that they were in use.

In a separate interview with RPN #114 and PCP #115 indicated that residents #018, #022, and #023's above specified equipment was not in use on the above identified date. The RPN also indicated that resident #020 did not have the equipment for the last two months. RPN #114 and PCP #115 indicated that residents #018, #020, #022, and #023 did not have the above specified falls prevention and management equipment on the above identified date.

(C) Residents #019, #024, #025, #026, #027, and #028 were observed on an identified date and time and did not have an identified communication device accessible to them.

-Resident #026 and #028's above specified communication devices were observed tied to two different specified areas and were not accessible to the residents.
-Resident #019, #024, #025, #027's above specified communication devices

were observed hanging on the floor and were not accessible to the residents.

Record review of resident #019, #024, #026, #027, and #028's, plan of care indicated they were at moderate to high risk for falls. Resident #025's was identified at a low risk for fall.

Resident #024, #025, #026, #027's falls prevention intervention indicated for staff to ensure the above specified communication devices were clipped to their clothing. For residents #019 and #028 the interventions indicated that the specified communication device should be within their reach at all times.

Interview with RPN #114 indicated that residents #026 and #028, were able to use the specified communication device for assistance. They further indicated the night PCP and registered staff both were responsible to ensure that residents above specified communication devices were within their reach. Residents #019, #024, #025, #026, #027, and #028 should have had the above specified communication device within reach or clipped to their clothing.

Interview with PCP #116 indicated that they did not check if the above mentioned residents had the above specified communication device within reach or clipped to their clothing on the above identified date, during an identified shift.

Review of the home's policy on Resident s Falls Prevention Program (LTC-CA-WQ-200-07-08), Last revised on June 2019, Appendix #4, indicated two above specified equipment are used by the home as part of their falls prevention and injury reduction strategies. Appendix #1 of the policy indicated under universal fall precautions implemented by the home that the above specified communication device should be within reach of the residents.

Interview with RAI-MDS coordinator #138 identified that as per the home's falls prevention program, two above specified equipment were used as specific strategies for the residents, to mitigate their fall risk. They further explained that under the universal fall precautions implemented by the home, the above specified communication device should be clipped to the residents clothing or within their reach. They further reviewed resident #015, #016, #017, #018, #019, #020, #022, #023, #024, #025, #026, #027, and #028's records and indicated that they were required to have fall prevention interventions implemented as

identified in their plan of care on the above identified date.

Interview with physiotherapist #136 indicated that residents #015, #016, #017, #018, #019, #020, #022, #023, #024, #025, #026, #027, and #028 used the above specified falls prevention and management equipment as preventative measures to mitigate their fall risk and should be used at all times.

Interview with ADOC #133 indicated that the above specified equipment were interventions used by the home for the falls prevention and management program. They further acknowledged that the specified falls prevention interventions were not implemented for the above mentioned residents.

The severity of this issue was determined to be a level 2 as there was a minimal harm to the residents. The scope of the issue was a level 2 as it related to nineteen of thirty-eight residents reviewed. The home had a level 2 history of previous non-compliance to a different subsection of the Act. Additionally, the LTCH has a history of three other compliance orders in the last 36 months.
(654)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 24, 2020

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l’article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 18th day of October, 2019

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Simar Kaur

Service Area Office / Bureau régional de services : Central East Service Area Office