

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

Rapport d'inspection en vertu de  
la Loi de 2007 sur les foyers de  
soins de longue durée

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

Division des opérations relatives aux  
soins de longue durée  
Inspection de soins de longue durée

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**Public Copy/Copie du rapport public**

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Feb 24, 2022	2022_892762_0005	001461-22	Complaint

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**Licensee/Titulaire de permis**

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as  
General Partner  
7070 Derrycrest Drive Mississauga ON L5W 0G5

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**Long-Term Care Home/Foyer de soins de longue durée**

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

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

MOSES NEELAM (762)

**Inspection Summary/Résumé de l'inspection**

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

**This inspection was conducted on the following date(s): February 7-11 and 14-16, 2022**

**In this complaint inspection the following intakes were inspected:**

**- Log related to various care items**

**During the course of the inspection, the inspector(s) spoke with with the Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Wound Care Nurse (WCN), and Director of Care (DOC)**

**The inspectors toured the home, observed the residents, provision of care, staff to resident interaction, clinical health records, complaint records, and relevant policies and procedures**

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

**Personal Support Services**

**Skin and Wound Care**

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

**1 WN(s)**

**1 VPC(s)**

**0 CO(s)**

**0 DR(s)**

**0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: 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. (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).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the resident's substitute decision-maker, is given an opportunity to participate fully in the implementation of the resident's plan of care.

A complaint was made to the director regarding the administering of a treatment, despite refusal from the Power of Attorney (POA), A review of the progress notes indicated that the Power of Attorney (POA) refused consent for the administration of the treatment. A review of the documentation record indicated that the the treatment was administered. In an interview RCC #107 indicated that the intervention was administered due to a miscommunication. As a result, the resident received a treatment without consent.

Sources: Progress notes and other record review; interview with RCC #107 [s. 6. (5)]

***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 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, to be implemented voluntarily.***

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**Issued on this 25th day of February, 2022**

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

**Original report signed by the inspector.**