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 prévue 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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 3, 2019	2019_533115_0010	008500-17, 020925-17, 027242-17, 005249-18, 008422-18, 016369-18, 019242-18, 032518-18, 033417-18, 007776-19, 008023-19	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 Westmount Long Term Care Residence
200 David Bergey Drive KITCHENER ON N2E 3Y4

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

TERRI DALY (115), AYESHA SARATHY (741), DEBRA CHURCHER (670)

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 15, 16, 17, & 18, 2019

The following Critical Incident inspections were conducted:
Related to falls prevention:
Critical Incident Log #033417-18/2880-000015-18
Critical Incident Log #019242-18/2880-000008-18
Critical Incident Log #008023-19/2880-000004-18
Critical Incident Log #007776-19/2880-000010-19

Related to alleged resident to resident abuse:
Critical Incident Log #008500-17/2880-000006-17
Critical Incident Log #020925-17/2880-000015-17
Critical Incident Log #016369-18/2880-000006-18
Critical Incident Log #005249-18/2880-000002-18
Critical Incident Log #032518-18/2880-000014-18
Critical Incident Log #008422-18/2880-000005-18

Related to alleged inappropriate care:
Critical Incident Log #027242-17/2880-000019-17

During the course of the inspection, the inspector(s) spoke with the Administrator, two Co-Directors of Care (Co-DOC), a Registered Nurse (RN), three Registered Practical Nurses (RPN), the Behaviour Support Ontario (BSO) Team Lead, and nine Personal Support Workers (PSW).

The inspector(s) also made observations of residents, resident and staff interactions and care and services. Reviewed relevant policies and procedures, as well as clinical records and plans of care for identified residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

2 WN(s)
1 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. 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 failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy is in compliance with and is implemented in accordance with all applicable requirements under the Act.

In accordance with O. Reg. 79/10, s. 30, the licensee was required to have a written description of each of the interdisciplinary programs required under section 48 of this Regulation, including a falls prevention and management program, that includes relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes. Specifically, the home's "Resident Falls" policy, last revised December 2017, which is part of the home's falls prevention and management program, was not in compliance with the applicable requirements under the Act.

In accordance with O. Reg. 79/10, s. 49 (2), when a resident had fallen the licensee was required to ensure the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

The home submitted a Critical Incident (CI) Report to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, related to the fall of a resident that resulted in a transfer to the hospital.

A Morse Falls Risk Assessment was completed for the resident on a specific date, and

indicated that the resident was a high risk for falls.

The home's policy titled "Resident Falls", last revised December 2017, was reviewed and stated that following a resident fall, Registered Staff would review the residents fall history to determine how many falls the resident had in the month and how many falls the resident had in the quarter. Combined with the level of risk related to falls, Registered Staff would use the number of falls in the month/quarter to determine if a Post Fall Analysis is to be completed. For high risk residents, a Post Fall Analysis would be completed if it was the first fall in the quarter and would not be completed if it was more than the first fall in the quarter.

During an interview, with the Co-Director of Care (Co-DOC) #112 they stated that a Post Fall Analysis was not completed for this specific resident after the fall noted in the CI, and it was the home's expectation that a Post Fall Analysis would be completed after every fall a resident has. Co-DOC #112 added that they were made aware last year that the home's policy titled "Resident Falls" was not compliant with the legislation, as it stated that the Post Fall Analysis was to be completed after each fall of the quarter for high risk residents. They said that the home's policy was in the process of being revised, but acknowledged that currently it was not in accordance with legislative requirements. [s. 8. (1) (a),s. 8. (1) (b)]

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 O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

The home submitted a Critical Incident (CI) Report to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, related to the fall of a resident that resulted in a transfer to the hospital and a significant change in health condition. The CI stated that on a specific date the resident was found on the floor mat. Several days later an X-ray was ordered. The results of the X-ray showed that the resident had a fracture, and the resident was sent to the hospital for further investigation and treatment.

A review of the resident's clinical record on Point Click Care (PCC) showed that there was no documented evidence that a post-fall assessment had been completed after the fall.

During an interview with Registered Practical Nurse (RPN) #111, they said that a post-fall assessment should be completed after every fall of a resident.

During an interview with the Co-Director of Care (Co-DOC) #112 they said that it is the home's expectation that a post-fall assessment would be completed after every fall of a resident. Co-DOC #112 was asked whether a post-fall assessment was completed after the fall of this resident, and they said it had not been completed and should have been. [s. 49. (2)]

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 a post-fall assessment is conducted using a clinically appropriate assessment instrument, specifically designed for falls when a resident has fallen and where the resident was assessed and that where the condition or circumstances of the resident required, to be implemented voluntarily.

Issued on this 9th day of May, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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) :	TERRI DALY (115), AYESHA SARATHY (741), DEBRA CHURCHER (670)
Inspection No. / No de l'inspection :	2019_533115_0010
Log No. / No de registre :	008500-17, 020925-17, 027242-17, 005249-18, 008422-18, 016369-18, 019242-18, 032518-18, 033417-18, 007776-19, 008023-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 3, 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 Westmount Long Term Care Residence 200 David Bergey Drive, KITCHENER, ON, N2E-3Y4
	Dawna Courtney

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

Ministère 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

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:

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

Ministère 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

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. 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 8 (1)(a).
The licensee shall prepare, submit, and implement a plan to ensure the "Resident Falls" policies are in compliance with the applicable requirements under the Act.

The plan must include, but is not limited, to the following:

a) A description of the intended changes to the "Resident Falls" policies.

b) A description of how the revised "Resident Falls" policies will be fully implemented and complied with.

c) A description of the training and education that will occur for all registered staff on the revised "Resident Falls" policies, who will be responsible for providing the education, and the dates this training will occur. Ensure a record is kept of all this information.

Please submit the written plan for achieving compliance for inspection #2019_533115_0010 to Terri Daly, LTC Homes Inspector, MOHLTC, by email to LondonSAO.moh@ontario.ca by May 17, 2019.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy is in compliance with and is implemented in accordance with all applicable requirements under the Act.

In accordance with O. Reg. 79/10, s. 30, the licensee was required to have a written description of each of the interdisciplinary programs required under section 48 of this Regulation, including a falls prevention and management program, that includes relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes. Specifically, the home's "Resident Falls" policy, last revised December 2017, which is part of the home's falls prevention and management program, was not in compliance with the applicable requirements under the Act.

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The severity of this issue was determined to be a level 2 as there was minimal risk of harm to residents. The scope of the issue was a level 3 widespread as it affects all residents. The home had a level 3 compliance history previous non compliance that included:
- Written Notification (WN) and Voluntary Plan of Correction (VPC) issued November 2, 2016.
(741)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 05, 2019

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 3rd day of May, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : TERRI DALY

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