Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 3, 2021	2021_729615_0029	006972-21, 007742-21, 008088-21, 008375-21, 008387-21, 008682-21, 010280-21, 011832-21, 015306-21	Critical Incident System

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

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

HELENE DESABRAIS (615), SHERRI COOK (633)

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): October 5, 6, 7, 12, 13, 14, 18, 19, 20 and 21, 2021.

The following intakes were inspected during this inspection:

Log #008088-21, Log #008375-21 and Log #011832-21 related to falls prevention; Log #006972-21, Log #007742-21, Log #008387-21, Log #008682-21, Log #010280-21 and , Log #015306-21 related to prevention of abuse, neglect and retaliation.

During the course of the inspection, the inspector(s) spoke with the Administrator, two Co-Director of Care (Co-DOC), the Registered Nurse - Behavioural Support Ontario Lead (RN-BSO), one RN, the Registered Practical Nurse - Infection Prevention and Control Lead (RPN-IPAC), two RPNs, the Personal Support Worker - Behavioural Support Ontario (PSW-BSO), two PSWs, two Housekeepers, a Dietary Aide and residents.

The inspectors also observed resident rooms and common areas, observed IPAC practices within the home, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed Critical Incident System (CIS) reports, reviewed the home's internal investigation reports and reviewed relevant policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
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. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written staffing plan for the programs provided for a staffing mix that was consistent with residents' assessed care and safety needs for residents.

A Critical Incident Report and the home's investigation stated that on a specific day a unit of the home was left unattended for approximately 2.5 hours. During that time a resident stated they activated the call bell because they were experiencing pain and needed their medication. When a PSW started their shift on that unit, they noticed that there were no staff present on the unit and four residents' call bells were ringing. The PSW attended the resident's room and the resident was upset because they had been waiting for 2.5 hours for their medication. The PSW looked at the call bell display at the nursing station and observed that some call bells had been ringing for approximately 100 minutes.

A Co-DOC stated that the home's process when a staff member did not arrive for their scheduled shift was that the RN was to be notified. The RN would then ensure that staff on the unit were aware including the RPN on the unit involved. On the evening of the incident, when the PSW on the unit finished their shift, they told the RN in charge that no PSW showed up on the unit for the shift. The RN assumed that the unit was going to be covered and did not advise the RPN of any staff shortages. Neither the RN or RPN followed the home's process.

Sources: Resident's clinical records, the home's Critical Incident System report, the home's investigation notes and interviews with a Co-DOC and a PSW. [s. 31. (3) (a)]

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. 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 the home's Ordering and Receiving Medication policy and procedures were complied with for a resident.

O. Reg. 79/10, s.114 (2) requires that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration of drugs used in the home.

Specifically, staff did not comply with the home’s policy and procedures “Ordering and Receiving Medication” that requires two nurses to check and process a physician’s order for medication.

The home’s physician ordered a medication to be administered daily for a resident. Nineteen days later, the resident was experiencing symptoms which were related to not receiving the prescribed medication. The resident’s family member then raised concerns to the home that the medication had been prescribed, but had not been administered to the resident since it was ordered.

A Co-DOC stated that when the physician ordered the medication 19 days prior, one nurse checked the transcription, but no one completed the second check so the medication was not processed.

Sources: Resident's clinical record, the home’s Critical Incident System report, the home’s investigation notes, the home’s Ordering and Receiving Medication’s policy (Last reviewed July 2014) and interviews with a Co-DOC. [s. 8. (1) (b)]

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 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, is complied with, to be implemented voluntarily.

Issued on this 3rd day of November, 2021

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	HELENE DESABRAIS (615), SHERRI COOK (633)
Inspection No. / No de l'inspection :	2021_729615_0029
Log No. / No de registre :	006972-21, 007742-21, 008088-21, 008375-21, 008387-21, 008682-21, 010280-21, 011832-21, 015306-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 3, 2021
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
LTC Home / Foyer de SLD :	Chartwell Westmount Long Term Care Residence 200 David Bergey Drive, Kitchener, ON, N2E-3Y4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Dawna Courtney

Ontario

Ministry of Long-Term Care

Ministère 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

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 Long-Term Care

Ministère 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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Order / Ordre :

The licensee must comply with s. 31 (3) (a) of O. Reg. 79/10.

Specifically, the licensee must:

-Ensure that at the beginning of each shift, the RN or assigned RPN attend each unit to ensure there are sufficient staff to meet the care and safety needs of the residents. Documentation by registered staff that this has been done should be kept in the home.

-Develop and implement an auditing process to ensure that registered staff are attending each unit at shift change to ensure there are sufficient staff to meet the residents care and safety needs.

-Document the staff member responsible for the audits and keep records of the audits for a period of four months and until no concerns arise.

Grounds / Motifs :

1. The licensee has failed to ensure that the written staffing plan for the programs provided for a staffing mix that was consistent with residents' assessed care and safety needs for residents.

A Critical Incident Report and the home's investigation stated that on a specific day a unit of the home was left unattended for approximately 2.5 hours. During that time a resident stated they activated the call bell because they were experiencing pain and needed their medication. When a PSW started their shift on that unit, they noticed that there were no staff present on the unit and four residents' call bells were ringing. The PSW attended the resident's room and the resident was upset because they had been waiting for 2.5 hours for their medication. The PSW looked at the call bell display at the nursing station and observed that some call bells had been ringing for approximately 100 minutes.

A Co-DOC stated that the home's process when a staff member did not arrive for their scheduled shift was that the RN was to be notified. The RN would then ensure that staff on the unit were aware including the RPN on the unit involved. On the evening of the incident, when the PSW on the unit finished their shift, they told the RN in charge that no PSW showed up on the unit for the shift. The RN assumed that the unit was going to be covered and did not advise the RPN of any staff shortages. Neither the RN or RPN followed the home's process.

Sources: Resident's clinical records, the home's Critical Incident System report, the home's investigation notes and interviews with a Co-DOC and a PSW. [s. 31. (3) (a)]

An order was made by taking the following factors into account:

Severity: There was actual harm to a resident as they were experiencing pain and needed their medication and no staff was on the unit to attend to them and there was actual risk for all residents on that unit since there were no staff available to respond to their care needs.

Scope: The scope of this non-compliance was isolated as there was one unit out of six affected.

Compliance history: No previous non-compliance to this section have been

issued to the home in the past 36 months. (615)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 16, 2021

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 Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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 Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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 des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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 des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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 November, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Helene Desabrais

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