Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 18, 2020	2020_817652_0006	012184-20, 012658-20	Complaint

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 Westbury Long Term Care Residence
495 The West Mall ETOBICOKE ON M9C 5S3

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

NATALIE MOLIN (652), GORDANA KRSTEVSKA (600)

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): July 2, 6, 7, 10, 14, 15, 17, 20, and September 15, 16, 2020. This was an off-site inspection.

During this inspection intakes related to an allegation of abuse and plan of care had been inspected.

During the course of the inspection, the inspector(s) spoke with The Acting Administrator, Acting Director of Care (ADOC), Registered Nurse (RN) Registered Practical Nurse (RPN), Personal Support Worker (PSW) and substitute decision maker (SDM).

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

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	
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 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 :

The licensee has failed to ensure that resident #001's substitute decision-maker, had been provided the opportunity to participate fully in the development and implementation of the plan of care.

A complaint submitted to the Ministry of Long-Term Care(MLTC) indicated, a family member had concerns regarding isolation of resident #001 after their outpatient visits to the hospital. The complainant stated that after the resident was taken to their follow-up appointments, upon return to the nursing home, they were isolated for two weeks. The complainant also said, that if they were made aware of the practice regarding isolation of the resident each time they went out, or that the follow up appointments were not essential for improving the resident's condition, they would not have taken the resident to the appointments, because the isolation increased the resident's decline in their overall health condition.

In interviews, the complainant confirmed that they took the resident to their follow up appointments mostly to get the resident outside to be with the family member because of the restriction on visitation, but if they were told about the practice by the home to keep the resident on isolation for 14 days upon their return from outside appointments, they would have cancelled the appointments, because the resident was not happy staying in the room on isolation.

A record review indicated, that the resident's family member had taken the resident to their follow-up outpatient appointments and did not indicate whether or not the home had discussed with the family member the benefits and disadvantages of the follow up appointments and isolation.

In an interview with the Registered Nurse (RN), Registered Practical Nurse (RPN) and Director of Care (DOC) they acknowledged that they did not discuss with the family member the benefits and disadvantages of the follow up appointments and isolation.

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 substitute decision-maker, is provided the opportunity to participate fully in the development and implementation of the plan of care, to be implemented voluntarily.

Issued on this 21st day of September, 2020

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

Original report signed by the inspector.