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

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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
Jun 2, 2021	2021_833763_0009	015586-20	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 Westbury Long Term Care Residence
495 The West Mall Etobicoke ON M9C 5S3

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

IANA MOLOGUINA (763)

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 8, 12, 14, 15, 16, 19, 20, 2021.

The following intakes were completed during this Critical Incident System (CIS) Inspection:

- Log #015586-20, CIS#2943-000015-20 was related to improper care.

PLEASE NOTE: A Written Notification and Voluntary Plan of Correction related to O. Reg. 79/10 s. 73. (1) 10, identified in a concurrent inspection #2021_833763_0008 (Log #005733-21) were issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Directors of Care (DOC), Infection Prevention and Control (IPAC) Lead, Food and Nutrition Manager (FNM), Registered Nurses (RN), Registered Practical Nurses (RPN), and Personal Support Workers (PSW). Additionally, the inspector spoke with entrance screening staff, as well as housekeeping, agency and recreation staff.

During the course of this inspection, the inspector reviewed residents' clinical records and conducted observations, including staff-resident interactions, meal observations and resident care provision.

The following Inspection Protocols were used during this inspection:
Medication
Nutrition and Hydration

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 O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that PSW #104 used proper techniques to assist a resident when they fed them while standing.

Record review indicated that the resident was newly admitted to the home, required a texture-modified diet and assistance for feeding. PSW #104 was observed providing feeding assistance to the resident at lunch. The staff fed the resident the main meal while standing.

PSW #104 confirmed they fed the resident while standing for part of the meal, and that this was an unsafe feeding technique. The home's Food and Nutrition Manager indicated that staff were expected to sit when feeding residents to decrease the risk of choking and provide a more comfortable eating experience for residents.

Sources: resident clinical records (care plan, PointClickCare profile), meal observations, staff interviews (PSW #104, FNM #118). [s. 73. (1) 10.]

2. The licensee has failed to ensure that RPN #119 and RN #109 used proper techniques to assist a resident with feeding.

The resident required a specified nursing intervention for feeding due to a pre-existing medical condition. Record review indicated that the resident required assistance to fix the intervention and the RN put in place a temporary measure. The RN continued to provide the specified nursing intervention by using the temporary measure and the oncoming RN did the same. The Nurse Practitioner (NP) assessed the resident and instructed the staff to stop as the resident was not tolerating it. The resident was then sent to hospital for further assessment and returned to the home shortly with no ill effects.

The home provided education to both staff after the incident to reiterate that staff were not to use the temporary technique to provide the specified nursing intervention as part of best practice nursing standards. DOC #116 confirmed the staff used an unsafe feeding technique in this incident as it increased the risk of infection for the resident.

Sources: resident clinical records (PointClickCare profile, progress notes, eMAR, physical chart records), CIS #2943-000015-20, home investigation notes, staff interviews (RPN #119, RN #109, RN #106, DOC #111, and DOC #116). [s. 73. (1) 10.]

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 ensuring that staff use proper techniques to assist residents with eating, to be implemented voluntarily.

Issued on this 4th day of June, 2021

[redacted]

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

Original report signed by the inspector.