Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: June 5, 2023	
Inspection Number: 2023-1318-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc.	
Long Term Care Home and City: Chartwell Wenleigh Long Term Care Residence, Mississauga	
Lead Inspector Parminder Ghuman (706988)	**Inspector Digital Signature** Parminder S Ghuman Digitally signed by Parminder S Ghuman Date: 2023.06.05 15:56:22 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 17, 19, 23- 26 & 29, 2023.

The following intake(s) were inspected:

- Intake: #00007252 - Critical Incident (CI) # 2833-000004-22- Potential overall neglect and improper care from LTC home towards resident; skin and wound care, dehydration, bathing, oral care, personal care, residents' drug regimes.
- Intake: #00008224 - CI # 2833-000013-22- Potential neglect and improper skin/wound care sustained to resident from a possible improper transfer/injury from staff.
- Intake: #00022183 - IL-10873-TO/IL-12051-TO/IL-12198-TO/IL-13660- Complainant concerns with neglect regarding skin and wound care and oxygen care; also, administration of drugs, falls prevention, Plan of care, & Training and Orientation program.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Licensee to forward complaints

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 22 (1)

The licensee has failed to ensure that written complaint that was received by the home concerning the care of a resident was immediately forwarded to the Director.

Rationale and Summary

A written complaint was received by the home on a specified date in January of 2022. The Director of Care (DOC) and Administrator met the family in February of 2022 but failed to report the concern immediately to the Director. The Administrator acknowledged that this CI was not submitted immediately after receiving the written complaint from the family concerning the care of the resident.

Not reporting matters concerning the care of resident immediately to the Director could potentially put the residents at risk of harm for neglect.

Sources: CI # 2833-000004-22, Resident's progress notes and interview with Administrator.

[706988]

WRITTEN NOTIFICATION: Licensees who report investigations under s. 27 (2) of Act

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (1)

The licensee has failed to ensure in making a report to the Director under subsection 27 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged neglect of a resident by the licensee or staff that led to the report.

Rationale and Summary

Critical Incident (CI) # 2833-0000013-22 was submitted on a specified date for potential neglect and improper skin/wound care sustained by the resident. The Director of Care (DOC) has failed to provide:

1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.

3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.

4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.

5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.

Not reporting a report to the Director under subsection 27 (2) of the Act, could potentially put the residents at risk of harm for neglect .

Sources: CI # 2833-0000013-22, Resident's progress notes and interview with Director of Care.

[706988]

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier 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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.