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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: August 30, 2023	
Inspection Number: 2023-1097-0002	
Inspection Type: Critical Incident	
Licensee: Chartwell Master Care LP	
Long Term Care Home and City: Chartwell White Eagle Long Term Care Residence, Toronto	
Lead Inspector Nicole Ranger (189)	**Inspector Digital Signature** Nicole S Ranger Digitally signed by Nicole S Ranger Date: 2023.08.31 10:24:18 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 22, 23, 24, 2023
The inspection occurred offsite on the following date(s): August 29, 2023

The following intake(s) were inspected:

- Intake: #00094596 - allegation of resident abuse, residents' bill of rights

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: RESIDENTS' BILL OF RIGHTS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.

The licensee has failed to ensure that residents had their personal health information within the meaning of the Personal Health Information Act, 2004, kept confidential in accordance with the Act.

Rationale and Summary
A Critical Incident (CI) report was submitted to the Director of a complaint received alleging abuse by a staff towards residents and breach of residents' personal health information. According to the complainant, Registered Practical Nurse (RPN) #101 employed by the home, privately disclosed to them various abuse incidents towards residents and disclosed three residents' personal health information.

The complainant reported that disclosure of resident #003's medical diagnosis and responsive behaviors were made during a phone conversation they had with RPN #101. The complainant further describes resident #001's family history, language spoken, and responsive behavior, in a specific manner.

The home's privacy and confidentiality policy required staff members at the home to keep resident's personal health information and information that was not made available or disclosed to unauthorized individuals.

RPN #101 stated that they did disclose residents' personal health information to the complainant and acknowledged that residents' personal health information should have been kept confidential.

The home's mobile communication device policy noted that personal communication devices (i.e. cell phones) must be stored in the staff's locker, or purse, and must not be carried while at work in the work environment. At no time was a personal communication device to be used for taking resident or resident involved event pictures.

RPN #101 stated that they would often take their personal break near a common resident area. RPN #101 stated that there were times when the complainant overheard staff to staff conversations related to residents and may have overheard residents speaking in the background.

RPN #101 also stated that they did take pictures of a resident involved event using their personal cell

phone. RPN #101 acknowledged that they should not have used their personal cell phone to record resident involved events or use their personal phone to make personal calls within vicinity of residents.

The Administrator stated that staff were expected to follow the home's privacy, confidentiality, and mobile device policy, and acknowledged that RPN #101 breached residents' personal health information and confidential information without their consent.

Sources: Home's mobile communication device and privacy and confidentiality policy, investigation notes, resident's progress notes; interviews with RPN #101, PSW #102, and the Administrator.

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