Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 20, 2017	2017_324535_0003	004674-17	Complaint

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

VERON ASH (535)

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): January 25, 26, and March 1, 2, 2017.

The following Complaint was inspected concurrently:
Log # 033860 - related to abuse

During the course of the inspection, the inspector(s) spoke with Executive Director, Co-Director of Care (co-DOC), MDS Coordinator, Program and Social Services Manager, Infection Prevention and Control Lead, registered staff, personal care providers (PCP), resident and family member.

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

During the course of this inspection, Non-Compliances were issued.
6 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	Legendé 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure residents were protected from abuse by staff in the home.

An identified complaint was received by the MOH on an identified date from a resident in the home who stated concerns of being targeted by staff and that staff initiated changes to the resident's care and services in the home.

On an identified date, a resident reported to the inspector that on an identified date the PCP was alerted because tray service for lunch was unusually late and the resident thought they might have forgotten to deliver the meal tray. The resident also stated that a DOC came into his/her room and communicated with the resident in a raised voice and with displayed facial anger. The resident was receiving tray services for an extended period of time in the home; and the home was content to maintain that service until recently. The resident was self-conscious of his/her condition and therefore did not want to attend the dining room for meals.

During the first interview, DOC #102 confirmed that upon admission the resident was attending the dining room for meals for a short period; then because of the identified medical condition, tray service was provided for an extended period. However, since the resident started to complain about the food/meals the home team decided to call the family and request a meeting. On an identified date, the team and family met and discussed multiple concerns regarding the resident’s plan of care and other related complaints/concerns. The DOC also stated that the resident was not present at the meeting at the family's request. The DOC further stated that he/she had multiple interactions with the resident, however the resident only requested to speak with the home’s Executive Director (ED) #100 to report that he/she was not included in the family meeting and was not a part of the decisions made at the meeting.

During an interview the home’s ED confirmed that the resident requested to meet with him/her on an identified date to report an inappropriate interaction with DOC #102. According to the ED, the resident felt upset and angered because of that interaction; and therefore he/she prompted the DOC to apologize to the resident for the inappropriate interaction. The ED also requested that the other DOC in the home assumed direct care and respond to complaints and concerns related to the resident going forward.

During the second interview, DOC #102 confirmed that there was an incident which occurred on an identified date when he/she used a rough tone in how he/she spoke to the resident. The DOC also confirmed that he/she was made to apologize to the resident. Record review and interviews with resident and staff confirmed that an abusive

interaction occurred between the resident and the DOC; therefore, the licensee failed to ensure that the resident was protected from abuse by a staff in the home. [s. 19. (1)]

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 residents were protected from abuse by anyone in the home, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents’ Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident’s individuality and respects the resident’s dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity.

An identified complaint was received by the MOH on an identified date from a resident in the home who stated concerns of being targeted by staff and that staff initiated changes to the resident's care and services in the home.

During an interview, the resident stated that he/she had asked registered staff #103 to leave a message for DOC #101 on an identified date; so that he/she could discuss a few concerns. On an identified date, during an interview with DOC #101, the inspector asked if he/she had received a message from the past week stating that the resident wanted to have a meeting. The DOC stated that he/she had received the message but was busy and had not responded to the resident. During an interview, the ED stated the expectation was that if a resident left a message requesting to speak with the DOC, he/she should respectfully get back to the resident in a timely manner or at least inform the resident when he/she would be available to speak with them. The ED also confirmed that the resident was not treated with courtesy and respect. [s. 3. (1) 1.]

2. The licensee has failed to ensure that a resident was fully respected and promoted the right to participate in decision-making.

An identified complaint was received by the MOH on an identified date from a resident in the home who stated concerns of being targeted by staff and that staff initiated changes to the resident's care and services in the home.

A review of the resident's Minimum Data Set documentation showed that the resident was cognitively intact and capable of making decisions independently. However, on an identified date a care conference was held at the home to review the resident plan of care, and the following members were invited to participate: the SDM, DOC #101, DOC #102, Food Service Manager, Social Services Worker #105, and registered staff #104. The resident was not in attendance at the meeting.

A review of the progress notes and multiple interviews confirmed that during the meeting, the family and care team discussed significant changes to the resident's plan of care and other related complaints/concerns of the resident.

During an interview, the resident stated that he/she should have been at the meeting since the decisions made were related to his/her care and services. During an interview with registered staff #104 and DOC #101, they both confirmed the people in attendance. However, during an interview with the ED, he/she confirmed that the resident should have been present at the meeting; and that the resident's right to participate in decision-

making was not respected and promoted by the home. [s. 3. (1) 9.]

3. The licensee has failed to ensure that the resident was respected and promoted the right to have his or her lifestyle and choices respected.

An identified complaint was received by the MOH on an identified date from a resident in the home who stated concerns of being targeted by staff and that staff initiated changes to the resident's care and services in the home.

Record review indicated that a care conference was held at the home on an identified date, with the multidisciplinary team and the resident SDM in attendance. A review of the progress notes and multiple interviews confirmed that during the meeting, the family and care team discussed significant changes to the resident’s plan of care; and discussed other related complaints/concerns.

During an interview, the resident stated that he/she had been enjoying a particular service in the home since an identified date shortly after admission to the home; however the progress notes indicated that this particular service was discontinued immediately following the care conference with the care team and family.

The progress notes also indicated that over a period of approximately six months, the resident refused the new service arrangements made by the home and the family. And, on an identified date, the registered staff documented that the resident was encouraged several times to accept the newly arranged service, however the resident continued to refuse.

During interviews with DOC #102 and #103, they both acknowledged that this episode of changing the resident's plan of care did not promote the resident's right to have his or her lifestyle and choices respected. During an interview with the home's ED, he/she confirmed that the resident should have participated in the decision to change his/her plan of care. Therefore, the licensee failed to ensure the resident's right to have his or her lifestyle and choices respected. [s. 3. (1) 19.]

WN #3: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

An identified complaint was received by the MOH on an identified date from a resident in the home who stated concerns of being targeted by staff and that staff initiated changes to the resident's care and services in the home.

Record review showed that the resident was cognitively intact and capable of making decisions independently. Record review also indicated that on an identified date, a family meeting was held at the home with members of the care team and the resident's substitute decision maker (SDM) in attendance. The SDM decided to exclude the resident from the meeting and the care team accepted that the family would update the resident with regards to the discussions and decisions made once the meeting was over.

A review of the progress notes showed that during the family meeting, the care team identified the need to implement a specific change in service for the resident related to a possible negative outcome. The home team also informed the family that the resident was experiencing this negative outcome while service was provided. The notes showed that family members did not agree with the change in service initially, however, they agreed after being informed by the care team that the resident was experiencing a negative outcome. The resident's care plan was updated on an identified date by DOC #101; and the progress notes and staff interviews revealed that over a six month period, the resident continued to refuse the change in service offered by the home at least once or twice each day.

During an interview, the resident informed the inspector that he/she was offered limited options in a specific service by the home; and interviews with registered staff #103 and 104, both confirmed the same. The staff also stated that the limit in service was provided following directions given by both DOCs in the home. Because of the limited service offered to the resident compared to the service outlined in the resident's plan of care, it was realized that the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy which promotes zero tolerance of abuse and neglect of residents was complied with.

An identified complaint was received by the MOH on an identified date from a resident in the home who stated concerns of being targeted by staff and that staff initiated changes to the resident's care and services in the home.

On an identified date, during an interview with the home's ED #100, he/she identified two separate documents with written incidents of alleged abuse involving a resident. The first incident was on an identified date; and it showed that a registered staff had a negative verbal interaction with the resident during the shift. During an interview, DOC #101 stated that neither of the home's two DOCs had investigated the reported negative interaction towards the resident. The second incident occurred on an identified date and was a complaint written by the resident to the ED. The complaint stated that a DOC had a negative interaction with the resident. During an interview, the ED confirmed that he/she was aware of the complaint; but that he/she did not have investigative notes related to the incident.

The home's Abuse Free Communities – Prevention, Education and Analysis Policy #LTC-CA-WQ-100-05-18, dated July 2010 and revised in November 2015, March 2016, and July 2016, states that 'zero tolerance' means the employer will not tolerate any form of resident abuse as defined within this policy. The employer will respond to all reports of resident abuse and the prescribed disciplinary actions will be specific to the unique circumstances of each case, as determined by the investigation (including but not limited to witness statements). Therefore, by not investigating and responding to both alleged negative interactions with the resident, the licensee failed to ensure the home's policy was complied with. [s. 20. (1)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any person with reasonable ground to suspect abuse of a resident by anyone that resulted in harm or risk of harm to the resident shall immediately report the suspicion and information upon which it was based to the Director.

An identified complaint was received by the MOH on an identified date from a resident in the home who stated concerns of being targeted by staff and that staff initiated changes to the resident's care and services in the home.

On an identified date, during an interview with the home's ED, the inspector was shown two separate documents with written incidents of alleged negative interactions with a resident in the home. The documents had identified dates; and indicated that a DOC and a registered staff displayed negative interactions towards a resident. During an interview, the ED confirmed that he/she was aware of these complaints of negative interaction with the resident; however these alleged incidents were not forwarded to the Director. [s. 24. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, ensure that the investigation commenced immediately.

An identified complaint was received by the MOH on an identified date from a resident in the home who stated concerns of being targeted by staff and that staff initiated changes to the resident's care and services in the home.

On an identified date, during an interview with the home's ED, the inspector was shown two separate documents with written incidents of negative interactions with a resident in

the home. The first incident was on an identified date and indicated that a registered staff engaged in a negative interaction with the resident. During an interview, registered staff #103 stated that he/she documented the information from the resident on the complaint form and gave it to one of the DOCs; however, the staff could not recall which DOC he/she gave the form to because of the passage of time. During an interview DOC #101 stated that neither of the home's two DOCs had investigated the incident towards the resident.

The second incident had an identified date and was a complaint written by the resident to the ED. The complaint indicated that a DOC engaged in a negative interaction with the resident. During an interview, the ED confirmed that he/she was aware of the complaint; however, he/she did not investigate the issue, provided a response to the resident within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, ensure that the investigation commenced immediately. [s. 101. (1) 1.]

2. The licensee has failed to ensure that a documented record was kept in the home that includes the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant.

An identified complaint was received by the MOH on an identified date from a resident in the home who stated concerns of being targeted by staff and that staff initiated changes to the resident's care and services in the home.

On an identified date, during an interview with the home's ED, the inspector was shown two separate documents with written incidents of alleged negative interactions with a resident in the home. The first incident had an identified date and showed that a registered staff had a negative interaction with the resident. The second incident had an identified date and was a complaint written by the resident to the ED. The complaint stated that a DOC had a negative interaction with the resident. The home's Social Services Worker #105 confirmed that these two complaints were not documented in the home's complaint work log; and that there was no documentation of the type of complaint, action to resolve the complaint and response to the complainant. [s. 101. (2)]

Issued on this 22nd day of March, 2017

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

Original report signed by the inspector.