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
Nov 3, 2020	2020_780699_0016	015794-20, 018705-20	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

PRAVEENA SITTAMPALAM (699)

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): October 15-16, 19-21, 2020.

The following complaint intakes were inspected:

-Log #015794-2 related to resident rights; and
-log #018705-20 related to plan of care not being followed.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Social worker (SW), registered nurse (RN), registered practical nurse (RPN), recreation aide, and personal care provider (PCP).

During the course of the inspection, the inspector conducted observations of staff and resident interactions, provision of care, record review of resident and home records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Personal Support Services
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. (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 resident #002 as specified in the plan.

The Ministry of Long-term Care (MLTC) received a complaint regarding an incident involving resident #002. It was identified that resident #002 exhibited a specified responsive behaviour which would not be compliant with the outbreak prevention measures that were in place at the time of the incident. Resident #002 had a plan of care in place which included having an identified intervention to manage their specified behavior related to outbreak prevention measures. This intervention was communicated to the nursing staff and the substitute decision maker (SDM). A PSW was assigned to work with resident #002 on the date of the incident. They stated they were unaware that the above intervention was in place and was not implemented on the day of the incident. Therefore, the licensee has failed to ensure that resident #002's was plan of care was followed.

Sources: Progress notes, care plan, email communication, interviews with SW #100, DOC #102, PSW #104, and RPN #107. [s. 6. (7)]

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Issued on this 5th day of November, 2020

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

Original report signed by the inspector.