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
Dec 21, 2021	2021_642698_0019	013003-20, 018530-20, 008938-21	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

ORALDEEN BROWN (698)

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): October 28-29, and November 1-5, 2021.

The following intakes were completed during this Critical Incident System (CIS) inspection:
Log #018530-20, CIS #2943-000018-20 related to abuse and Log #013003-20, CIS #2943-000012-20 was related to plan of care.

One follow-up log #005733-21 related to s. 229. (4) of O. Reg. 79/10 related to home's Infection Prevention and Control (IPAC) program, compliance order (CO) #001 from inspection report #2021_833763_0008 with a compliance due date of August 02, 2021.

During the course of the inspection, the inspector(s) spoke with the Directors of Care (DOCs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Infection Prevention and Control (IPAC) lead and resident.

During the course of the inspection, the inspector(s) conducted observations of residents, staff and resident interactions, and the provision of care; conducted review of resident health
records, the home's internal investigation notes, policies and procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 229. (4)	CO #001	2021_833763_0008	698

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of a resident.

A Critical Incident System (CIS) report was submitted to the Director related to improper care of a resident. The home identified that there was delayed treatment for a resident's wounds.

Review of electronic health records indicated that a resident required multidisciplinary interventions and did not receive assessments and interventions until four months after the initial discovery of their wounds.

The home’s investigation notes indicated that staff and multidisciplinary team members were not involved in the collaboration of the different aspects of care regarding assessment of the resident which resulted in the deterioration and spread of their wounds. Registered staff did not collaborate with the multidisciplinary team by sending referrals as per the home’s policy. The resident experienced deterioration after it was brought to the attention of a registered staff on several occasions. The resident did not receive a comprehensive assessment when they experienced these deteriorations. The registered staff over the course of four months did not collaborate with the multidisciplinary team to ensure that the resident received a comprehensive assessment.

Sources: Resident #002's electronic clinical records, CIS report #2943-000012-20, home’s investigation notes, Wound Care Treatment, Policy #LTC-CA-WQ-200-08-03 (revision date December 2017) and staff interviews. [s. 6. (4) (a)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident's wounds were reassessed at least weekly by a member of the registered staff.

The resident's wounds were not assessed weekly over a four-month period and during that time the wounds got worse. A Registered Nurse (RN) acknowledged that the resident's wounds were not assessed more often because of workload issues. This gap in weekly assessments increased the likelihood that appropriate care would not be in place to treat the wounds if they started to get worse.

Sources: Resident #002's electronic clinical records, CIS report #2943-000012-20, home's investigation notes, Wound Care Treatment, Policy #LTC-CA-WQ-200-08-03 (revision date December 2017) and staff interviews. [s. 50. (2) (b) (iv)]

Issued on this 11th day of January, 2022

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

Original report signed by the inspector.