Ontario

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

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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
Toronto ON M2M 4K5
Telephone: 1-866-311-8002
TorontoSAO.moh@ontario.ca

Original Public Report

Report Issue Date June 27, 2022
Inspection Number 2022_1427_0001
Inspection Type
☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
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 and City
Chartwell Westbury Long Term Care Residence
495 The West Mall Etobicoke ON M9C 5S3

Lead Inspector
Noreen Frederick (704758)

Inspector Digital Signature
Noreen Frederick
Digitally signed by Noreen Frederick
Date: 2022.06.28 16:19:25 -04'00'

Additional Inspector(s)
Christine Francis (740880) attended this inspection during orientation.

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 26, 27, June 6, 7, 8, 9, 10, 2022.

The following intake(s) were inspected:

- Log #006323-22 (Complaint) related to Skin and Wound Care and Maintenance Services
- Log #008006-22 (Complaint) related to Residents' Bill of Rights and Duty to Protect
- Log #008380-22 (Complaint) related to Duty to Protect

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

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Pain Management
- Prevention of Abuse and Neglect

- Residents' Rights and Choices
- Skin and Wound Prevention and Management

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#01 remedied pursuant to FLTCA, 2021, s. 154(2)

Findings of Non-Compliance were found during this inspection and were ***remedied*** prior to its conclusion. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

LTCHA, 2007 s. 15 (2) (c)

On June 9, 2022, the following rooms #807, 816, 819, 814, 810, 801, 824 and 809 were found to have holes in the wall under the bathroom sink exposing pipes and insulation. This was brought to the Executive Director's attention the same day.

Environmental manager confirmed with the inspector on June 10, 2022, that all the repairs were completed which were checked by the inspector.

Date Remedy Implemented: June 10, 2022 [704758]

WRITTEN NOTIFICATION PLAN OF CARE

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 6 (4) (a)

The licensee has failed to ensure that Personal Support Workers (PSWs) collaborated with the Registered Practical Nurses (RPNs) in the assessment of resident #001 when they experienced pain during personal care and transfers.

Rationale and Summary

Resident #001 stated that they experienced pain during personal care and transfers. Resident #001's plan of care identified personal care and transferring activities as a trigger for their pain and registered staff to offer analgesia prior to initiating care. Resident had an order for two Pro

Re Nata (PRN) medications to manage their pain, which were not administered prior to care and transfers. PSWs did not document the resident's pain in Point of Care (POC).

PSWs #100, #101, and #102 were aware that resident #001 experienced pain during personal care but did not communicate with the registered staff. The Registered Practical Nurses (RPNs) did not receive any communication from the PSWs about resident #001's pain.

By not collaborating, there was a risk of resident #001's pain not being managed.

Sources: resident #001's clinical records, interviews with RPN #102, #103, #105, PSW #100, #101, #102 and DOC #107.

[704758]

COMPLIANCE ORDER [CO#001] FLTCA, 2021, S. 24 (1)

NC#03 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021 **DUTY TO PROTECT**

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with s. 24 (1).

The licensee must be compliant with s. 24 (1) of the FLTCA, 2021

Specifically, the licensee must:

1. Retrain RPN #105 and RN#110 related to their roles, and responsibilities when a resident is exhibiting sign and symptoms which are outside of their normal baseline, including assessment and when to call a physician and notify Substitute Decision Maker (SDM).

2. The home must maintain a record of the above education, including the date, content, who facilitated the education, and signed staff attendance.

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Grounds

Non-compliance with: FLTCA, 2021 s. 24 (1)

The licensee has failed to ensure that resident #002 was not neglected.

In accordance with the definition identified in section 7 of the Ontario Regulation 246/22 "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary

Resident #002 exhibited sudden unusual symptoms on one identified date, which was outside of their baseline. Physician and Substitute Decision Maker (SDM) were called after several hours. Resident was diagnosed with a condition for which a treatment was available and according to the hospital, the resident was no longer a candidate for that specific treatment as the timeline has passed.

PSW #106 stated that when they found the resident, they looked different, therefore they reported this to RPN #105. RPN #105 did not notify the physician or SDM about the resident's change in condition. RN #110 who took over from RPN #105, did not complete any assessments or vital signs during their shift when they received the resident, and did not think that the physician and SDM needed to be called. RPN #103 knew that resident's signs and symptoms required medical attention when they assessed the resident on an identified date; therefore they called the physician and received an order to transfer them to hospital. Nurse Practitioner (NP) #112 and Medical Doctor (MD) #113 acknowledged that if the resident have been sent to hospital sooner, they would have received the treatment they required sooner.

Due to the inaction of RPN #105 and RN #110, resident #002 was not a candidate for a specific treatment, and their treatment was delayed, which they required for their health, safety and well-being.

Sources: resident #002's clinical records, interviews with RPN #105, RN #110, NP #112 and MD #113.

[704758]

This order must be complied with by August 15, 2022

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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. Please include the inspection report # and the order or AMP #;
(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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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:

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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
email: 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.