Ontario

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

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

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

Original Public Report

Report Issue Date: March 29, 2023	
Inspection Number: 2023-1427-0004	
Inspection Type: Complaint Critical Incident System	
Licensee: Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc.	
Long Term Care Home and City: Chartwell Westbury Long Term Care Residence, Etobicoke	
Lead Inspector Rajwinder Sehgal (741673)	**Inspector Digital Signature** Rajwinder Sehgal Digitally signed by Rajwinder Sehgal Date: 2023.03.30 13:24:39 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):
March 15-16, 21-23, 2023

The following intake was inspected in this Critical Incident System (CIS) inspection:

- Intake: #00015758 – [CI: 2943-000025-22] related to falls.

The following intake was inspected in this complaint inspection:

- Intake: #00020048 – [IL-09925-TO] related to alleged physical abuse towards a resident.

The following intake was completed in the Critical Incident System (CIS) Inspection:

- Intake: #00008794 – [CI: 2943-000018-22] related to falls.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls 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 #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that when a resident was reassessed, the plan of care was revised when the resident's care needs changed.

Rationale and Summary
A resident was assessed by the Physiotherapist (PT) and recommended to use specified level of assistance for transfers. The resident's care plan was not updated to reflect this change.

The Director of Care (DOC) acknowledged that the resident's care plan did not identify that they were to receive required level of assistance for transfers.

The intervention to use specific level of assistance for transfers was updated in the care plan on March 22, 2023.

Failure to ensure that a resident's care plan is up to date may result in an increased risk for injury and an incorrect level of care provided in response to the resident's care needs.

Sources: Resident's care plan, progress notes, PT progress notes, interviews with Registered Nurse (RN), and DOC.

[741673]

Date Remedy Implemented: March 22, 2023

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident had occurred that resulted in harm to the resident, immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary
A complaint was submitted to the Ministry of Long-Term Care (MLTC) alleging the physical abuse of a resident.

The home received a verbal concern from the resident's Substitute Decision Maker (SDM) regarding alleged physical abuse to the resident. The resident's progress notes indicated that the resident was found with injuries of an unknown cause.

The home's policy titled "Complaints" dated April 2022 indicated that an investigation will be initiated immediately into any complaint, written or verbal, that alleges harm or risk of harm, including but not limited to physical harm, to one or more residents and homes must immediately report this type of complaint to the Director.

In an interview, the DOC acknowledged that the alleged abuse was not reported to the Director as per legislative requirements.

The home's failure to immediately report to the Director the alleged abuse of resident, may have delayed the Director's ability to respond to the incident in a timely manner.

Sources: Review of Critical Incident System portal, home's complaint record, home's Complaints policy #LTC-CA-WQ-100-05-08, last revised April 2022 and interview with DOC.

[741673]