Ontario

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

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

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

Original Public Report

Report Issue Date: November 20, 2023

Inspection Number: 2023-1427-0007

Inspection Type:
Complaint
Critical Incident

Licensee: Regency LTC Operating Limited Partnership, by it general partners, Regency Operator GP Inc. and AgeCare Iris Management Ltd.

Long Term Care Home and City: AgeCare Westbury, Etobicoke

Lead Inspector	**Inspector Digital Signature**
Irish Abecia (000710)	Irish J Abecia Digitally signed by Irish J Abecia Date: 2023.11.27 09:57:14 -05'00'

Additional Inspector(s)
Parimah Oormazdi (741672)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 6-10, 2023

The following intake were inspected in this Critical Incident (CI) inspection:

- Intake: #00100438 [CI: 2943-000011-23] - related to a disease outbreak

The following intakes were inspected in this Complaint inspection:

- Intake: #00098837 - related to prevention of abuse and neglect, and medication administration
- Intake: #00099700 - related to prevention of abuse and neglect
- Intakes: #00100097, #00100211 - related to a disease outbreak

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)

The licensee has failed to ensure that symptoms indicating the presence of infection were monitored for a resident, in accordance with the Infection Prevention and Control (IPAC) Standard.

The home failed to ensure that syndromic surveillance of symptoms, including but not limited to, fever new coughs, nausea, vomiting, and diarrhea, and taking appropriate action in accordance with the IPAC Standard.

Specifically licensee failed to ensure that symptoms indicating the presence of infection were monitored for a resident, as required by the Additional Requirement

under 3.1 (i) the IPAC Standard for Long-Term Care Homes .

Rationale and Summary
A resident was identified with respiratory related symptoms. A physician assessed the resident and recommended to monitor their symptoms.

The home's Daily Infection Surveillance policy directed staff to document on the Daily Infection Surveillance Form and monitor resident's symptoms daily.

A Registered Practical Nurse (RPN) verified that they did not complete the Daily Infection Signs and Symptoms Tracking Form for the resident on identified dates. The IPAC lead confirmed that the resident's symptoms should have been monitored every shift.

Failure to follow the directions related to monitoring the resident's symptoms may have contributed to the late detection and treatment of symptoms.

Sources: a resident's clinical records, Daily Infection Surveillance Form, home's policy, interviews with staff, IPAC Standard for Long-Term Care Homes.

[741672]

WRITTEN NOTIFICATION: NOTIFICATION RE INCIDENTS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (b)

The licensee has failed to ensure that a resident's Substitute Decision-Maker (SDM) was notified within 12 hours upon the licensee becoming aware of a suspected

incident of abuse of the resident.

Rationale and Summary
An RPN documented they found a resident hitting another resident with an item and screaming at them. The resident exhibiting responsive behaviours was immediately redirected away from the other resident for safety. The RPN acknowledged that they did not notify the affected resident's SDM on the day of the incident since the resident did not require any immediate medical interventions.

Several days later, another RPN had discussed the incident with the affected resident's SDM and discovered that the SDM was not notified. The Director of Care (DOC) acknowledged that the affected resident's SDM should have been notified immediately after the incident when the RPN became aware of the suspected incident of abuse.

Failure to ensure that the resident's SDM was notified within 12 hours upon becoming aware of any suspected incident of abuse may lead to the SDM's inability to participate in the development and implementation of the resident's plan of care.

Sources: residents' clinical records; Home's investigations notes; Interviews with staff

[000710]