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
May 7, 2021	2021_792659_0011	002525-21, 005854-21, 007024-21	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 Westmount Long Term Care Residence
200 David Bergey Drive Kitchener ON N2E 3Y4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JANETM EVANS (659)

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): April 29, 30 and May 3, 2021.

The following intakes were completed during this inspection: Log #002525-21, related to alleged abuse of a resident by staff, Log #005854-21, related to alleged abuse of a resident by staff, and Log #007024-21, related to alleged abuse of a resident by staff,

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), two Co-Directors of Care (DOC), a Registered nurse (RN), the Infection Prevention and Control Lead (IPAC), Personal Support Workers (PSWs), a housekeeper, screeners, a tester and residents.

The inspector completed observations of dining, housekeeping, infection prevention and control (IPAC) measures and general resident care. A review of documentation which included but was not limited to resident plans of care, progress notes, home's investigation, electronic Medication Record, screening and testing logs and relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff fully participated in the implementation of the infection prevention and control program in relation to assisting residents with hand hygiene.

The inspector completed multiple observations on multiple units of the home between April 29 and May 3, 2021, and observed that on three units, staff did not assist six residents with hand hygiene prior to a meal or snack, following a meal or snack, or following personal care.

The IPAC Lead said residents were encouraged to sanitize their hands before and after meals and after continence care and that staff would usually assist them with this.

Not assisting residents with hand hygiene placed staff, essential visitors and residents at increased risk for disease transmission.

Sources: Observations, Hand Hygiene Program, Interviews with staff, and the IPAC lead. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff assist residents to complete hand hygiene before and after meals and snacks, and following personal care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

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

A family member sent an email to the Co-DOC, reporting care concerns involving a resident and that staff had been mean to the resident. They asked the home to investigate the concerns.

The alleged incident was not reported to the Director, until the following day and only after the family requested this.

The Co-DOC acknowledged that they did not immediately report the incident to the Director.

Not immediately reporting suspected improper or incompetent treatment or care of a resident, may increase the potential for risk of harm to residents.

Sources: Critical Incident System report (CIS), home's investigation, interview with Co-DOC #100. [s. 24. (1)]

Issued on this 14th day of May, 2021

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

Original report signed by the inspector.