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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901
centralwestdistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: December 15, 2022

Inspection Number: 2022-1365-0003

Inspection Type:
Complaint
Critical Incident System (CIS)

Licensee: Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner

Long Term Care Home and City: Chartwell Westmount Long Term Care Residence, Kitchener

Lead Inspector	**Inspector Digital Signature**
Alicia Campbell (741126)	Alicia Campbell Digitally signed by Alicia Campbell Date: 2023.01.09 08:45:11 -05'00'

Additional Inspector(s)
Kim Byberg (729)

INSPECTION SUMMARY

The Inspection occurred on the following date(s): Onsite: November 8-9, 14-18, 21 and 28, 2022. Offsite: November 22-25, 2022.

The following intake(s) were inspected during this CIS inspection:

- Intake: #00003742, CIS#2880-000019-22 - related to an allegation of abuse towards a resident

The following intake(s) were inspected during this Complaint inspection:

- Intake: #00006111 - related to an allegation of abuse towards a resident, medication management, staffing and resident plan of care

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

Infection Prevention and Control

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)
O.Reg. 246/22, s. 102 (2) (b)

The Licensee failed to ensure that the Infection Prevention and Control (IPAC) Standard, as issued by the Director, was implemented.

The IPAC Standard for Long-Term Cares Homes, dated April 2022, section 9.1 states at a minimum, additional precautions shall include point of care signage that enhanced IPAC control measures are in place.

Specifically, the licensee failed to post additional precaution signage at the door to resident #005's room. RPN #106 confirmed resident #005 was on isolation and additional precautions signage should have been posted.

On November 9, 2022, additional precautions signage was observed posted on resident #005's door.

Date Remedy Implemented: November 9, 2022.

[741126]

COMPLIANCE ORDER CO #001 Prevention of Abuse and Neglect

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with FLTCA, 2021, s. 24(1)

The licensee shall:

a) Develop a written procedure that outlines the steps to be taken, as well as the roles and responsibilities of staff when a resident identifies that they do not want to receive care from a specific caregiver.

b) Ensure that all PSW's, RPN's, RN's, and the management team are provided education in relation to the written process developed in part a).

c) Document the education, as outlined in b), including the date, format, staff who completed the training, and staff member who provided the education.

Grounds
The licensee failed to protect resident #001 and #002 from sexual abuse by Personal Support Worker (PSW) #117.

"Sexual abuse" is defined as, any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member. O. Reg. 246/22, s. 2(1)

Rational and Summary

A) Resident #001 told their family member that a staff member had been inappropriate towards them. Resident #001 told their family that it had happened before, but they did not report it.

Resident #001 told inspector #729 that PSW #117 was inappropriate towards them. Resident #001 stated they told the PSW to stop. The incident was very upsetting for the resident.

Resident #001 informed staff member #112 that PSW #117 was inappropriate towards them, and they had to ask them to stop.

Staff member #111 said that resident #001 repeatedly told them they did not want PSW #117 to do their showers. Staff member #111 did not think anything of it at the time and did not report the refusal or request to not have PSW #117 do their care to anyone. A review of previous bathing documentation

for resident #001 showed that they refused bathing from PSW #117 every week over a seven month period.

The home completed an investigation into the allegation. During the home's investigation, there was a secondary allegation of abuse by PSW #117 towards resident #002. Additionally, four staff members alleged that PSW #117 made inappropriate comments and gestures towards them.

The local Police Service was notified by the home and based on their investigation criminal charges were brought against PSW #117.

Resident #001 was fearful of the incidents and required medication and emotional intervention.

[729]

B) During the home's internal investigation in relation to the incident outlined in A), resident #002 reported that they were not comfortable with how PSW #117 provided personal care. Resident #002 said the inappropriate manner in which care was provided occurred on two occasions and they had to ask the PSW to stop.

During an interview, resident #002 indicated that a PSW was inappropriate towards them and they reported it to the home. They stated they had asked the staff member to stop.

Staff member #110 indicated that the manner in which care was provided without consent would be considered inappropriate.

Upon conclusion of the home's internal investigation into the allegations of abuse, PSW #117's employment was terminated with cause.

Resident #002 expressed feeling distraught and vulnerable after the situation.

[741126]

This order must be complied with by January 27, 2023

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

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NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #01
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $5500.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

Order #001 of Inspection 2022_729616_0002

This is the first time the licensee has failed to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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;
(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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) 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:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) 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:

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
e-mail: 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.