

**Inspection Report under  
the Long-Term Care  
Homes Act, 2007****Rapport d'inspection en vertu de  
la Loi de 2007 sur les foyers de  
soins de longue durée****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**Central West Service Area Office  
1st Floor, 609 Kumpf Drive  
WATERLOO ON N2V 1K8  
Telephone: (888) 432-7901  
Facsimile: (519) 885-2015Bureau régional de services de Centre  
Ouest  
1e étage, 609 rue Kumpf  
WATERLOO ON N2V 1K8  
Téléphone: (888) 432-7901  
Télécopieur: (519) 885-2015**Public Copy/Copie du rapport public**

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Nov 5, 2020	2020_800532_0023	017109-20, 018662- 20, 019916-20	Critical Incident System

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**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**

NUZHAT UDDIN (532)

**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): October 15-23, 2020.**

**The following intake was completed in this Critical incident inspection:**

**Log #019916-20, related to falls prevention.**

**Log #018662-20, related to abuse.**

**Log # 017109-20, related to abuse.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Directors of Care, (DOC), Nurse Manager, Resident Assessment Instrument (RAI) Coordinator, Behavioural Support Ontario (BSO) Registered Nurse, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.**

**The inspector also toured resident home areas, observed resident care provision, resident staff interaction, and reviewed relevant residents' clinical records, policies and procedures, video surveillance and training records pertaining to the inspection.**

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

**Falls Prevention**

**Prevention of Abuse, Neglect and Retaliation**

**Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**

**2 WN(s)**

**1 VPC(s)**

**1 CO(s)**

**0 DR(s)**

**0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification  VPC – Voluntary Plan of Correction  DR – Director Referral  CO – Compliance Order  WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit  VPC – Plan de redressement volontaire  DR – Aiguillage au directeur  CO – Ordre de conformité  WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

**Specifically failed to comply with the following:**

**s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident was protected from physical, emotional and verbal abuse by a PSW.

Section 2 (1) of the Ontario Regulation 79/10 defines emotional abuse as any threatening, insulting, intimidating or humiliating gesture, actions, behavior remarks, including imposed social isolation, shunning ignoring, lack of acknowledgement or infantilization that are preformed by anyone other than a resident.

Physical abuse means the use of force by anyone other than a resident that causes physical injury or pain.

Verbal abuse is defined as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth that is made by anyone other than a resident.

a) A PSW's conduct triggered a resident's responsive behaviours following which the staff member used physical force. The incident caused both emotional and physical harm to the resident.

Sources: CIS report, Video Surveillance, PSWs, RPN, BSO RN and other staff.

b) The licensee has failed to ensure that the resident was protected from physical abuse by a co-resident.

Section 2 (1) of the Ontario Regulation 79/10 defines physical abuse as the use of force by a resident that causes physical injury to another resident.

A PSW heard screaming and found that a resident was pulling on a co-resident. The co-resident sustained injuries related to this incident. The home did not protect the resident from abuse by another resident.

Source: CIS report, BSO RN, DOC and other staff interview. [s. 19. (1)]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6.  
Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised, (a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).**

**(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that care was provided to the resident as specified in the responsive behaviour plan of care.

Staff were given specific directions to address a resident's responsive behaviours. A PSW did not use the recommended approach as outlined in the responsive behaviour plan of care and did not ensure that the care was provided as directed.

Sources: CIS report, Video Surveillance, PSWs, RPN, BSO RN and other staff. [s. 6. (7)]

2. The licensee has failed to ensure that when the resident was reassessed related to falls prevention and the plan of care revised because care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care.

A resident was considered at risk for falls related to their history of falls, and related injuries. Staff were directed to ensure appropriate safety equipment was in use.

Different approaches were not considered in the revision of the plan of care when the staff member became aware that the resident was removing the safety equipment, which lead to a fall and related injuries.

Source : CIS report, PSWs, and Falls Lead RN. [s. 6. (11) (b)]

***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 the care set out in the plan of care is provided to the resident as specified in the plan; when a resident is reassessed and the plan of care reviewed and revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.***

**Issued on this 13th day of November, 2020**

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

**Original report signed by the inspector.**

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

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

**Public Copy/Copie du rapport public**

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**Name of Inspector (ID #) /**

**Nom de l'inspecteur (No) :** NUZHAT UDDIN (532)

**Inspection No. /**

**No de l'inspection :** 2020\_800532\_0023

**Log No. /**

**No de registre :** 017109-20, 018662-20, 019916-20

**Type of Inspection /**

**Genre d'inspection:** Critical Incident System

**Report Date(s) /**

**Date(s) du Rapport :** Nov 5, 2020

**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

**LTC Home /**

**Foyer de SLD :** Chartwell Westmount Long Term Care Residence  
200 David Bergey Drive, KITCHENER, ON, N2E-3Y4

**Name of Administrator /**

**Nom de l'administratrice**

**ou de l'administrateur :** Dawna Courtney

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**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
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foyers de soins de longue durée*, L.O.  
2007, chap. 8

To Regency LTC Operating Limited Partnership on behalf of Regency Operator GP  
Inc. as General Partner, you are hereby required to comply with the following order(s)  
by the date(s) set out below:

**Order(s) of the Inspector****Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

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l'article 154 de la *Loi de 2007 sur les  
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2007, chap. 8

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**Order # /****No d'ordre :** 001**Order Type /****Genre d'ordre :** Compliance Orders, s. 153. (1) (a)**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

**Order / Ordre :**

The licensee must be compliant with s. 19 (1) of the LTCHA.

Specifically, the licensee must:

- 1) Retrain the identified PSW on the resident's responsive behaviour plan of care and non-abuse policy.
- 2) Document the education that is provided to the PSW and include the date, the content of the education and the staff member who provided the education.

**Grounds / Motifs :**

1. 1. The licensee has failed to ensure that the resident was protected from physical, emotional and verbal abuse by a PSW.

Section 2 (1) of the Ontario Regulation 79/10 defines emotional abuse as any threatening, insulting, intimidating or humiliating gesture, actions, behavior remarks, including imposed social isolation, shunning ignoring, lack of acknowledgement or infantilization that are preformed by anyone other than a resident.

Physical abuse means the use of force by anyone other than a resident that causes physical injury or pain.

Verbal abuse is defined as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth that is made by anyone other than a resident.

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
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2007, c. 8

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

a) A PSW's conduct triggered a resident's responsive behaviours following which the staff member used physical force. The incident caused both emotional and physical harm to the resident.

Sources: CIS report, Video Surveillance, PSWs, RPN, BSO RN and other staff.

An order was made by taking the following factors into account:

Severity: A resident was subjected to physical, emotional and verbal abuse by a PSW, leading to actual harm.

Scope: This non-compliance was widespread as two out of two incidents of abuse were identified during this inspection that resulted in harm to a resident.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 19 (1) and two other Compliance Orders (CO) were issued to different sections of the legislation, all of which have been complied.  
(532)

**This order must be complied with by /  
Vous devez vous conformer à cet ordre d'ici le :**

Nov 16, 2020

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
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2007, c. 8

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

**REVIEW/APPEAL INFORMATION**

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
- (b) any submissions that the Licensee wishes the Director to consider; and
- (c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director  
c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
1075 Bay Street, 11th Floor  
Toronto, ON M5S 2B1  
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
Care Homes Act, 2007*, S.O.  
2007, c. 8

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar  
Health Services Appeal and Review Board  
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  
1075 Bay Street, 11th Floor  
Toronto, ON M5S 2B1  
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website [www.hsarb.on.ca](http://www.hsarb.on.ca).

**Order(s) of the Inspector**

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2007, c. 8

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

**RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX  
APPELS**

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le/la titulaire de permis souhaite que le directeur examine;
- c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur  
a/s du coordonnateur/de la coordonnatrice en matière d'appels  
Direction de l'inspection des foyers de soins de longue durée  
Ministère des Soins de longue durée  
1075, rue Bay, 11<sup>e</sup> étage  
Toronto ON M5S 2B1  
Télécopieur : 416-327-7603

**Order(s) of the Inspector****Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
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2007, c. 8

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l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)  
Commission d'appel et de révision  
des services de santé  
151, rue Bloor Ouest, 9e étage  
Toronto ON M5S 1S4

Directeur  
a/s du coordonnateur/de la coordonnatrice en matière  
d'appels  
Direction de l'inspection des foyers de soins de longue durée  
Ministère des Soins de longue durée  
1075, rue Bay, 11e étage  
Toronto ON M5S 2B1  
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web [www.hsarb.on.ca](http://www.hsarb.on.ca).

**Issued on this 5th day of November, 2020**

**Signature of Inspector /**

**Signature de l'inspecteur :**

**Name of Inspector /**

**Nom de l'inspecteur :** Nuzhat Uddin

**Service Area Office /**

**Bureau régional de services :** Central West Service Area Office