Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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
Jan 24, 2019	2018_587129_0013	007904-18	Critical Incident System

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

Long-Term Care Home/Foyer de soins de longue durée

Chartwell Brant Centre Long Term Care Residence
1182 Northshore Blvd. East BURLINGTON ON L7S 1C5

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

PHYLLIS HILTZ-BONTJE (129)

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): December 11, 2018, January 9 and 10, 2019.

The following Critical Incident Inspection was completed:
Log # 007904-18 (CIR #2900-000010-18) related to disease outbreak.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), PSW Coordinator and the Director of Care (DOC).

During the course of this inspection, the inspector observed resident care and residents environments, reviewed disease outbreak notes maintained by the Director of Care, reviewed training records related to the infection prevention and control, reviewed annual program evaluation records for 2017 and reviewed licensee's policies related to infection control.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **1 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 failed to ensure that all staff participated in the implementation of the Infection Prevention and Control Program.

While completing Critical Inspection #007904-18, related to Critical Incident Report (CIR) #2900-000010-18, it was noted that the licensee failed to ensure all staff participated in the Infection Prevention and Control Program (IPCP) when they failed to ensure infection precaution signage posted for residents provided clear direction to staff and others related to the specific precautions staff and others must take for identified residents, failed to ensure that Personal Protective Equipment (PPE) was available for the use of staff and others and failed to ensure that direct care staff used the required PPE.

On an identified date, observations were made for resident #006, resident #007 and resident #008. The following was noted:

1. Infection Prevention and Control (IPC) signage for resident #006's and resident #007's did not provide clear directions to staff and others regarding the infection precautions persons were to take for these two residents. Signage posted for both residents indicated two different types of precautions staff and others were to take.
During an interview on an identified date, Personal Support Worker (PSW) #121 confirmed when they enter resident #006's room they use an identified PPE and if they were to provide direct care to resident #006 they would use a second identified PPE, but acknowledged the signage did not provide clear direction to staff who may not be familiar with the resident or to others who may be entering the room.
During an interview on an identified date, PSW #122 indicated that they thought they were to use an identified precaution for resident #007, but acknowledged the signage did not provide clear direction to staff.
During an interview on an identified date, Practical Nurse (RPN) #123 confirmed that the infection precaution signage for resident #006's and resident #007's did not provide clear directions to staff and others regarding the infection control precautions that were required.
The licensee failed to ensure that staff participated in the Infection Prevention and Control Program when they failed to ensure that staff and others were provided with clear directions for the implementation of infection control precautions that were to be in place for resident #006 and resident #007.

2. The licensee did not ensure that Personal Protective Equipment (PPE) was available for the use of staff and others related to resident #006, resident #007 and resident #008.
On an identified date, observations were made of infection control precaution signage and the required use of PPE for the above note residents. One identified piece of PPE

that was required to be used for resident #006 was not available for the use of staff and others, two identified pieces of PPE that were required to be used for resident #007 where not available for staff and others to use and one identified piece of PPE that was required to be used for resident #008 was not available for the use of staff and others.

During an interview on an identified date, RPN #124 indicated they were not aware that the required PPE was not available for staff to use when providing care to resident #008, confirmed at this time resident #008 required infection prevention precautions and indicated they would ensure these supplies were made available for staff.

During an interview on identified date, RPN #122 acknowledged that resident #006 and resident #007 were required to have infection control precautions in place and the required identified PPE was not available for the use of staff and others.

The licensee did not ensure that all staff participated in the Infection Prevention and Control Program when it was observed that PPE had not been made available for the use of staff and others.

3. On an identified date, PSW #126 was observed to not wear the required PPE while providing direct care to resident #007. During an interview on the same day, PSW #126 confirmed they had not used one of the required pieces of PPE when they provided care to the resident.

Not all staff participated in the implementation of the licensee's Infection Control and Prevention Program when staff were observed to not use the required PPE.

It was confirmed through observations and staff interviews, that not all staff participated in the licensee's Infection Prevention and Control Program. [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 and ensuring that all staff participate in the Infection Prevention and Control Program, to be implemented voluntarily.

Issued on this 25th day of January, 2019

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

Original report signed by the inspector.