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

Hamilton District
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Original Public Report

Report Issue Date: March 28, 2023	
Inspection Number: 2023-1384-0002	
Inspection Type: Proactive Compliance Inspection	
Licensee: Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc.	
Long Term Care Home and City: Chartwell Brant Centre Long Term Care Residence, Burlington	
Lead Inspector Lisa Bos (683)	**Inspector Digital Signature** Lisa Bos Digitally signed by Lisa Bos Date: 2023.04.05 10:22:58 -04'00'
Additional Inspector(s) Daria Trzos (561)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 1, 2, 3, 6, 7, 8, 9 and 10, 2023

The following intake(s) were inspected:

- Intake: #00020202 - Proactive Compliance Inspection (PCI)

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

Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Quality Improvement
Pain Management
Falls Prevention and Management
Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices

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)
FLTCA, 2021, s. 85 (3) (a)

The licensee has failed to ensure that the revised Residents' Bill of Rights was posted in the home.

Rationale and Summary
During the initial tour of the home, it was observed that the old version of Residents' Bill of Rights under the Long-Term Care Homes Act, 2007, was posted in the home. When this was brought up to the home, they posted the revised version the same day.

Sources: Observations; interview with the Director of Care (DOC).
[561]

Date Remedy Implemented: March 1, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 85 (3) (c)

The licensee has failed to ensure that the long-term care home's policy to promote zero tolerance of abuse and neglect of residents was posted in the home.

Rationale and Summary
During the initial tour of the home, it was observed that the home's policy to promote zero tolerance of

abuse and neglect of residents was not posted. This was brought to the attention of the DOC and they rectified this the same day.

Sources: Observations; interview with the DOC.
[561]

Date Remedy Implemented: March 1, 2023

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 85 (3) (l)

The licensee has failed to ensure that copies of the inspection reports from the past two years for the long-term care home were posted in the home.

Rationale and Summary
During the initial tour of the home, it was observed that the Ministry of Long-Term Care inspection reports were not posted. This was brought to the attention of the DOC and they rectified the issue the same day and posted the binder with all inspection reports.

Sources: Observations and interview with the DOC.
[561]

Date Remedy Implemented: March 1, 2023

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 29 (3) 12.

The licensee has failed to ensure that a resident's plan of care was based on, at a minimum, interdisciplinary assessment of the dental and oral status, including oral hygiene with respect to the resident.

Rationale and Summary
A resident's admission assessment which was documented in the progress notes indicated their dental status. The plan of care was reviewed and did not include the dental status or oral hygiene with respect to the resident. The resident stated that they performed oral care independently. A Personal Support Worker (PSW) who provided direct care to the resident stated that assistance was provided daily regarding the resident's dental and oral status. A Registered Practical Nurse (RPN) confirmed the same and indicated that they would ensure that the care plan included the oral status and hygiene for the

resident.

Sources: Observations; review of the plan of care including progress notes and the written plan of care; interview with the resident, a PSW, RPN and the Assistant Director of Care (ADOC).
[561]

Date Remedy Implemented: March 8, 2023

NC #005 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 265 (1) 10.

The licensee has failed to ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act, included the current version of the visitor policy made under section 267.

Rationale and Summary
During the initial tour of the home, it was observed that the visitor policy was not posted. The DOC was interviewed and indicated that they would ensure that it was posted.

Sources: Observations and interview with the DOC.
[561]

Date Remedy Implemented: March 1, 2023

WRITTEN NOTIFICATION: Plan of care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that two residents were provided with nutrition interventions as per their plans of care.

Rationale and Summary
A) A resident was at nutritional risk and in accordance with their written plan of care, they required an adaptive device and nutrition intervention at meals. The resident was observed at meal service, and they were not provided with the adaptive device, as confirmed by a dietary aide. The resident was observed a second time during meal service and they were not provided with their nutrition intervention, as confirmed by a RPN.

The Registered Dietitian (RD) and Food and Nutrition Manager acknoweldged that the resident should have been provided with the adaptive device and nutrition intervention as per their plan of care.

There was risk that the resident would not meet their nutritional requirements when they were not provided with the nutrition intervention as per their plan of care.

Sources: Mealtime observations; a resident's clinical record; interview with the RD, Food and Nutrition Manager and other staff.
[683]

B) A resident was at nutritional risk and in accordance with their written plan of care, they required an adaptive device and nutrition intervention at meals. The resident was observed at meal service, and they were not provided with the adaptive device. The resident was observed a second time during meal service and they were not provided with their nutrition intervention.

The RD acknowledged that the resident required the adaptive device and that they should have been provided with it, as per their plan of care. The Food and Nutrition Manager acknowledged the resident required the nutrition intervention as per their plan of care.

There was risk that the resident would not meet their nutritional requirements when they were not provided with the adaptive device and nutrition intervention, as per their plan of care.

Sources: Mealtime observations; a resident's clinical record; interview with the RD, Food and Nutrition Manager and other staff.
[683]

WRITTEN NOTIFICATION: Directives by Minister

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every operational Minister’s Directive that applied to the long-term care home, the operational Minister’s Directive was complied with.

In accordance with the Minister’s Directive: COVID-19 response measures for long-term care homes, the

licensee was required to ensure that COVID-19 screening requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario was followed.

Rationale and Summary
The COVID-19 Guidance Document for Long-Term Care Homes in Ontario indicated that all staff working in a long-term care home must be tested for COVID-19 according to one of the following:
-an antigen test at least two times per week, on separate days, if they are up-to-date with recommended COVID-19 vaccine doses
-an antigen test at least three times per week, on separate days, if they are not up-to-date with recommended COVID-19 vaccine doses
-one PCR and one antigen test per week, at a minimum, on separate days

The home's screening protocol for COVID-19 indicated that all persons entering the home must be tested or show proof of having a negative test for COVID-19, and if testing was not done on site, individuals were to show proof of the negative test. The screener was required to record the date of the last test result for all staff.

The home's COVID-19 testing records were reviewed for a RPN and two PSWs for a two-week period. Each staff member worked between eight to eleven shifts and there was no documentation that the RPN was tested for COVID-19, and there was documentation that the PSWs were tested for COVID-19 on one occasion each.

One of the staff members reported that they were tested as required, but there was no supportive documentation. The Administrator reported that two of the staff members also worked at other locations, but acknowledged that they did not keep records to indicate if staff showed proof of having a negative test for COVID-19 upon entering the home, as confirmed by a screener.

The Administrator acknowledged that there was no documentation to support that the staff were tested as required.

There was risk of transmission of COVID-19 when there was no documentation to support that staff were tested as required.

Sources: Screening Protocol for COVID-19, policy #LTC-CA-ON-205-02-13; staff COVID-19 testing records; staff schedules; interviews with a screener, the Administrator and other staff.
[683]

WRITTEN NOTIFICATION: Communication and response system

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (f)

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that clearly indicated when activated where the signal was coming from.

Rationale and Summary
During the initial tour of the home, it was identified that when the call bells were activated in random residents' rooms, the signal did not clearly indicate where it was coming from. The PSW staff indicated that they used the pager system and the signal would be sent to their pagers; however, the pagers were not functioning at this time. Furthermore, the management was aware of the issue, but the pagers had not been fixed.

The Environmental Manager stated that they were not aware of the pagers being broken. When the DOC checked, they identified that a few of the pagers were either missing buttons, needed batteries replaced or the display which would show the room number of the call bell being activated, was not clearly visible. Other pagers were functioning; however, the PSW staff failed to keep them in their pockets. The DOC stated that at the beginning of the shift, registered staff on each unit were responsible to assign the pagers to each PSW team and ensure they were functioning. The DOC indicated that they were not aware of certain pagers being broken and they removed the non-functioning pagers and replaced them.

Failure to ensure that the resident-staff communication and response system was functioning increased the risk of residents not receiving assistance when required.

Sources: Observations; review of the Maintenance Order log; interview with PSW staff, registered staff, Environmental Manager and the DOC.
[561]

WRITTEN NOTIFICATION: Care conference

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 30 (1) (b)

The licensee has failed to ensure that a resident was given an opportunity to participate fully in their

annual care conference.

Rationale and Summary
A resident reported they had not been invited to an annual care conference. A review of their clinical record indicated that an interdisciplinary care conference was held within the past year, but there was no documentation that the resident was invited to or attended their care conference.

The Social Service Worker acknowledged that the resident should have been invited to their care conference and that the care conference should not have happened without them. They stated that there was no documentation to support if the resident was invited to or declined involvement in their most recent care conference.

Sources: A resident's clinical record; interview with a resident and the Social Service Worker.
[683]

WRITTEN NOTIFICATION: Dining and snack service

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.

The licensee has failed to ensure that foods and fluids were served at a temperature that was both safe and palatable to residents.

Rationale and Summary
A resident reported that the food was not always hot enough. A review of the food committee meeting minutes from the past three months indicated that residents had concerns regarding the food being cold.

The home's safe food temperatures guideline indicated that hot foods were to be held at 60 degrees Celsius (140 degrees Fahrenheit) or greater.

The Food and Nutrition Manager was asked to take the temperature of the hot food items during the lunch meal service on a resident home area. The temperature of a pureed food item was 138 degrees Fahrenheit, which they acknowledged was below the required hot holding temperature of 140 degrees Fahrenheit.

The home was aware that there were complaints regarding food temperatures over the past several

months. Failure to maintain a minimum food temperature of 140 degrees Fahrenheit as per the home's safe food temperatures guideline may have affected the palatability of the food, and had the potential to impact food safety.

Sources: Meal service observations; food temperatures; Safe Food Temperature guideline, policy #LTC-CA-WQ-300-04-02; review of the Food Committee meeting minutes; interview with a resident, the Food and Nutrition Manager and other staff.
[683]

WRITTEN NOTIFICATION: Housekeeping

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)

The licensee has failed to ensure that resident care equipment, specifically a commode chair, was cleaned and disinfected after use.

Rationale and Summary
In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that procedures were developed and implemented for cleaning and disinfection of the resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs.

Specifically, the staff failed to comply with Cleaning, Disinfection and Sterilization policy which stated that all resident used equipment should be cleaned and disinfected as soon as possible after use and definitely prior to use by or for another resident.

A soiled commode chair was observed on a resident home area. The PSW coordinator stated that the commode chair was used with a resident and should have been cleaned and disinfected prior to use and after use. A RPN confirmed the same.

Failing to clean and disinfect resident equipment prior and after use, may have increased the risk of transmission of infections.

Sources: Observations; review of home’s Cleaning, Disinfection and Sterilization policy; interview with a RPN, the PSW Coordinator and the Administrator.
[561]

WRITTEN NOTIFICATION: Maintenance Services

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (a)

The licensee has failed to ensure that procedures were implemented to ensure that mechanical lifts were kept in a good state of repair.

Rationale and Summary
The home's Maintenance Work Order and Log Book policy directed staff to enter requests for service in the log books located at the nursing stations and maintenance staff were required to monitor the log books daily and sign off when the repairs were completed.

A staff member reported concerns regarding broken mechanical lifts. A mechanical lift on a resident home area was observed to be missing the emergency release button. A staff member reported that the lift was still in use as it was functioning, but there was potential that residents could get stuck without an emergency release button.

The log book at the nursing station was reviewed and there was no documentation regarding the repair of the emergency release button for the mechanical lift.

The Environmental Supervisor reported they were unaware that there were any issues with the lift on the resident home area and did not receive any work orders regarding repairs for the unit. The Environmental Supervisor and a representative from Safety First Inc. (SFI) Medical acknoweldged that if staff were unable to use the remote for the lift, there was no safe way to get the resident down without the emergency release button, and the lift was unsafe.

Residents were placed at risk of harm when staff continued to use a mechanical lift without a functioning emergency release button, and failed to enter the request for maintenance in the log book so that the lift could be repaired.

Sources: Observations; Maintenance Work Order and Log Book policy #ALL-CA-ALL-505-02-05; interview with a staff member, the Environmental Supervisor and a representative from SFI Medical.
[683]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, issued by the Director, was implemented.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, dated April 2022, s. 9.1 (f) stated that at minimum additional precautions should be followed related to appropriate selection, application, removal and disposal of Personal Protective Equipment (PPE).

A registered staff member was observed administering a treatment to a resident who was on droplet precautions and the registered staff did not have a face shield applied. The home's policy Routine Practices and Additional Precautions, indicated that staff were to don gloves, gowns, eye protection, and surgical masks when within two meters of a resident on droplet precautions. It was confirmed that the registered staff should have worn a face shield when providing treatment to this resident.

Failing to apply proper PPE during direct contact with a resident who was on droplet precautions increased the risk of transmission of infection.

Sources: Observations; IPAC Standard issued by the Director; review of the home's Routine Practices and Additional Precautions policy; interview with a registered staff member and the DOC.
[561]