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

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Original Public Report

Report Issue Date: January 13, 2023	
Inspection Number: 2023-1392-0002	
Inspection Type: 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 Waterford Long Term Care Residence, Oakville	
Lead Inspector Lisa Bos (683)	**Inspector Digital Signature** Lisa Bos Digitally signed by Lisa Bos Date: 2023.01.13 13:17:10 -05'00'

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 5-6, 9-11, 2023

The following intake(s) were completed:

- Intake: #00001518, CIS #2908-000013-21 related to falls prevention and management;
- Intake: #00005831, CIS #2908-000016-21 related to falls prevention and management; and
- Intake: #00003938, CIS #2908-000010-22 related to the prevention of abuse and neglect.

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

Prevention of Abuse and Neglect
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Directives by Minister

NC #001 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 residents were to be assessed at least once daily for signs and symptoms of COVID-19, including temperature checks.

A Registered Practical Nurse (RPN) reported that all resident temperatures were taken daily by the registered staff using the "Resident COVID-19 Surveillance Tracking" document. The tracking tool was reviewed for a resident home area for a period of four days, and there was no documentation that resident temperatures were taken on two of the days.

A RPN and a Director of Care (DOC) acknowledged that temperatures were not taken for residents on the two identified dates, and should have been.

There was risk that symptoms of COVID-19 may have gone unnoticed when temperature checks were not completed at least once daily as required.

Sources: Resident COVID-19 Surveillance Tracking document; interview with a RPN and DOC.
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WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 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, dated April 2022, was implemented.

Rationale and Summary
The IPAC Standard for Long-Term Care homes, indicated under section 6.1 that the licensee shall make Personal Protective Equipment (PPE) available and accessible to staff and include having a PPE supply ensuring adequate access to PPE for routine and additional precautions.

The IPAC Standard for Long-Term Care homes, indicated under section 9.1 that additional precautions shall include (e) point-of-care signage indicating that enhanced IPAC control measures were in place.

A) During a tour of the home, signage for additional precautions was observed outside a resident's room, as confirmed by a PSW.

A DOC acknowledged that the resident required additonal precautions, but that the specific sign outside the resident's room was incorrect.

Failure to post the correct signage indicating that additional precautions were required may have increased the risk of transmission of infections.

Sources: Observations; interview with a PSW and a DOC
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B) On two consecutive days, an empty PPE caddy was observed on the door of a resident's room and there was no signage to indicate that additional precautions were required.

A review of the resident's clinical record indicated that they required additional precautions.

A DOC acknowledged that the resident required additional precautions and a RPN acknowledged that there was no signage on the resident's door to indicate that additional precautions were required, and that the PPE caddy was empty.

Failure to post signage indicating that additional precautions were required, and to have PPE available in the caddy, may have increased the risk of transmission of infections.

Sources: Observations; a resident's clinical record; interview with a RPN and a DOC
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