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: January 20, 2023	
Inspection Number: 2023-1405-0001	
Inspection Type: Critical Incident System	
Licensee: Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc.	
Long Term Care Home and City: Chartwell Willowgrove Long Term Care Residence, Ancaster	
Lead Inspector Stephanie Smith (740738)	**Inspector Digital Signature** Stephanie D Smith Digitally signed by Stephanie D Smith Date: 2023.01.24 09:13:05 -05'00'
Additional Inspector(s) Emma Volpatti (740883) Jobby James (694267) was on-site during this inspection	

INSPECTION SUMMARY

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

The following intake(s) were completed in this Critical Incident (CI) inspection:

- Intake: #00003180 and Intake: #00006373 related to falls prevention and management.

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

Infection Prevention and Control
Falls Prevention and Management

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 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 9.1 that Additional Precautions were to be followed in the IPAC program which included (e) point-of-care signage indicating that enhanced IPAC control measures are in place.

Observations revealed a resident had additional precautions signage on their room door.

The resident's clinical record indicated that they required specific additional precautions for an infection. Interviews with a Registered Nurse (RN) and a Registered Practical Nurse (RPN) confirmed that the resident did not require the posted additional precautions; they required another type of additional precautions.

During a later observation, the resident's door continued to have the same additional precautions signage. Later that day, the signage was changed to the required specific additional precautions.

There was no risk to the resident as they required less precautions than the signage indicated.

Sources: Observations, a resident's clinical record, interviews with an RN and an RPN.

[740738]

Date Remedy Implemented: January 11, 2023

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 failed to ensure that the 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 9.1 that Additional Precautions were to be followed in the IPAC program which included (f) additional personal protective equipment (PPE) requirements including appropriate selection and application.

During observations there was specific additional precautions signage present on a resident's door, which included an N95 mask. The resident was pending results for a suspected infection. A Personal Support Worker (PSW) was observed entering the room wearing a gown, gloves, face shield, and medical mask instead of an N95 mask.

The PSW acknowledged that they should have been wearing an N95 mask as per the signage on the door. The IPAC Lead confirmed that when a resident is on specific additional precautions, an N95 mask should be worn.

Failure to wear the required PPE posed a risk of spreading infection to other residents.

Sources: Interview with a PSW and the IPAC lead, observations of a resident's room, the IPAC Standard for Long-Term Care Homes, dated April 2022.

[740883]

WRITTEN NOTIFICATION: Emergency Plans

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (4) 3.

The licensee has failed to ensure that hand hygiene products provided in the home were not expired.

Rationale and Summary

The home was experiencing a COVID-19 outbreak that began on January 1, 2023 and remained in outbreak during the course of the inspection.

Observations in the home revealed that alcohol-based hand rub (ABHR) in multiple care areas was expired. Specifically, when staff assisted residents with hand hygiene prior to their lunch meal, the ABHR that was utilized had an expiry date of July 2022. The wall-mounted ABHR in a specified neighbourhood located outside the dining room, mud room, and the entrance to the neighbourhood all had an expiry date of December 2022. Furthermore, other areas throughout the home were observed to have expired wall-mounted ABHR with the same date of December 2022, including on the specified neighbourhood where most COVID-19 cases were at the beginning of the outbreak.

Observations on a specified neighbourhood revealed that expired ABHR was present on the PPE caddie outside two resident rooms. The expiry dates of both ABHRs was April 2022.

Interviews with the Administrator, Director of Care (DOC), IPAC Lead, Clinical Nurse, and Environmental Manager confirmed that expired ABHR with a date of December 2022 was being utilized in the home.

Failure to ensure that the ABHR products provided in the home were not expired, led to increased risk of transmission of infectious agents to residents and others.

Sources: Observations, interviews with Administrator and others.

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