Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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 East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 10, 2020	2020_838760_0039	024321-20	Critical Incident System

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 Woodhaven Long Term Care Residence
380 Church Street Markham ON L6B 1E1

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

JACK SHI (760)

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 9, 2020.

A log was related to an outbreak at the home.

During the course of the inspection, the inspector(s) spoke with a Housekeeper, a Dietary Aide, Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Social Worker, the Programs Manager, the Maintenance Manager, the Educator, the Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector conducted observations, interviews and record reviews.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 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 has failed to ensure that staff participated in the implementation of the Infection Prevention and Control (IPAC) program.

The home submitted Critical Incident System (CIS) report, related to an outbreak in the home.

According to the administrator, public health declared the entire home in a confirmed outbreak and staff were directed to follow precautions home wide. A number of residents and staff have been tested positive for the outbreak.

Observations were conducted by the inspector and noted the following:
- Three staff members were seen without their mask on while working in the home.
- Some of the garbage bins on different units of the home were overfilled with used personal protective equipment (PPE).
- Some PPE caddies located outside of resident's rooms did not have various sizes for staff to use.
- A manager took a gown out of a PPE caddie and left it hanging outside of a resident’s room. When they came back, they stated they were going to wear it as it they believed it was still clean as it was not used.
- Various PSWs were seen not donning or doffing PPE when entering and exiting resident rooms. A PSW was also observed not performing hand hygiene when entering and exiting resident rooms.
- On a unit that had multiple positive residents, garbage was seen being stacked and overflowed in front of the entrance of the unit. The staff on the unit indicated that there was no housekeeper on the unit to take the garbage out, so they were being taken out by the PSWs from the resident’s rooms and out of the unit by the housekeeping manager. The administrator indicated that the home did not have any housekeeping staff available to work on that unit.
- A PSW was observed without having full PPE on while taking out the garbage from the resident’s rooms, which contained used PPE from the resident's that have tested positive.
- An RPN indicated that they observed the housekeeping manager cleaning the high touch surfaces once during their shift.

An interview with the DOC and administrator indicated the following:
- Staff are always to wear their mask on while working on their shift.
- The home was aware that the garbage bins were too small to fit used PPE and was working to procure more bigger bins.
- The caddies should be stocked with various PPE sizes.
- Once a gown is taken out of a resident’s caddie, it is considered soiled and should be

disposed if it is not used. It should not have been hung outside of the resident's room to be used at another time.
- The PSWs and staff are to do a point of care risk assessment before deciding whether to put on full PPE or not. The administrator indicated that if staff cannot social distance themselves from the residents, they should be in full PPE.
- The administrator indicated that it was not acceptable to have garbage thrown and stacked right outside of the entrance of the unit and that this did not follow infection prevention and control (IPAC) practices of the home. The DOC added that the PSW should be wearing full PPE when taking garbage out from the designated unit.

As there was an outbreak at the home and the observations demonstrated that there were inconsistent IPAC practices from the staff of the home, no housekeeper on the unit designated for positive residents and inconsistent supply of PPE outside of resident's rooms, there was actual harm to the residents of the home. The risk associated to the staff not adhering to the home's IPAC program would be possible transmission of infectious agents during the ongoing outbreak in the home.

Sources: Interviews with PSWs, an RPN, a manager, the Administrator, the DOC and other staff; Record reviews of the line list of positive and observations made at the home. [s. 229. (4)]

Additional Required Actions:

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

Issued on this 10th day of December, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JACK SHI (760)
Inspection No. / No de l'inspection :	2020_838760_0039
Log No. / No de registre :	024321-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 10, 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 Woodhaven Long Term Care Residence 380 Church Street, Markham, ON, L6B-1E1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Andre Dwyer

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must be compliant with s. 229 (4) of O. Reg. 79/10.

Specifically, the licensee must:

1. Provide leadership, monitoring, and supervision in all home areas to ensure staff adherence with appropriate Infection Prevention and Control (IPAC) practices.

2. Provide on the spot education and training to staff not adhering with appropriate IPAC measures.

3. Ensure that all PPE caddies are fully stocked and that all caddies have all appropriate PPE in them.

4. Ensure that housekeeping staff are available on site and working on the designated unit.

Grounds / Motifs :

1. The licensee has failed to ensure that staff participated in the implementation of the Infection Prevention and Control (IPAC) program.

The home submitted Critical Incident System (CIS) report, related to an outbreak in the home.

According to the administrator, public health declared the entire home in a confirmed outbreak and staff were directed to follow precautions home wide. A number of residents and staff have been tested positive for the outbreak.

Observations were conducted by the inspector and noted the following:
- Three staff members were seen without their mask on while working in the home.
- Some of the garbage bins on different units of the home were overfilled with used personal protective equipment (PPE).
- Some PPE caddies located outside of resident's rooms did not have various sizes for staff to use.
- A manager took a gown out of a PPE caddie and left it hanging outside of a resident's room. When they came back, they stated they were going to wear it as it they believed it was still clean as it was not used.
- Various PSWs were seen not donning or doffing PPE when entering and exiting resident rooms. A PSW was also observed not performing hand hygiene when entering and exiting resident rooms.
- On a unit that had multiple positive residents, garbage was seen being stacked and overflowed in front of the entrance of the unit. The staff on the unit indicated that there was no housekeeper on the unit to take the garbage out, so they were being taken out by the PSWs from the resident's rooms and out of the unit by the housekeeping manager. The administrator indicated that the home did not have any housekeeping staff available to work on that unit.
- A PSW was observed without having full PPE on while taking out the garbage from the resident's rooms, which contained used PPE from the resident's that have tested positive.
- An RPN indicated that they observed the housekeeping manager cleaning the high touch surfaces once during their shift.

An interview with the DOC and administrator indicated the following:
- Staff are always to wear their mask on while working on their shift.
- The home was aware that the garbage bins were too small to fit used PPE and was working to procure more bigger bins.
- The caddies should be stocked with various PPE sizes.
- Once a gown is taken out of a resident's caddie, it is considered soiled and should be disposed if it is not used. It should not have been hung outside of the resident's room to be used at another time.
- The PSWs and staff are to do a point of care risk assessment before deciding whether to put on full PPE or not. The administrator indicated that if staff cannot social distance themselves from the residents, they should be in full PPE.
- The administrator indicated that it was not acceptable to have garbage thrown

and stacked right outside of the entrance of the unit and that this did not follow infection prevention and control (IPAC) practices of the home. The DOC added that the PSW should be wearing full PPE when taking garbage out from the designated unit.

As there was an outbreak at the home and the observations demonstrated that there were inconsistent IPAC practices from the staff of the home, no housekeeper on the unit designated for positive residents and inconsistent supply of PPE outside of resident's rooms, there was actual harm to the residents of the home. The risk associated to the staff not adhering to the home's IPAC program would be possible transmission of infectious agents during the ongoing outbreak in the home.

Sources: Interviews with PSWs, an RPN, a manager, the Administrator, the DOC and other staff; Record reviews of the line list of positive and observations made at the home.

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

Severity: There was actual risk of harm to the residents because the home was on an outbreak and there was potential for possible transmission of infectious agents due to the staff not participating in the implementation of the IPAC program, inconsistent supply of PPE outside resident's rooms and a lack of a housekeeper on one of the affected units.

Scope: The scope of this non-compliance was widespread because the IPAC related concerns were identified during observations throughout the home, and the non-compliance has the potential to affect a large number of the LTCH's residents.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with O. Reg 79/10 s. 224 (4) and one Written Notification (WN) and one Voluntary Plan of Correction (VPC) was issued to the home. (760)

Ontario

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Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Dec 16, 2020

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:

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.

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, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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 revision 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.

Issued on this 10th day of December, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jack Shi

Service Area Office /
Bureau régional de services : Central East Service Area Office