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

Toronto District
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Original Public Report

Report Issue Date: January 25, 2023	
Inspection Number: 2023-1427-0003	
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 Westbury Long Term Care Residence, Etobicoke	
Lead Inspector Christine Francis (740880)	**Inspector Digital Signature** Parimah Oormazdi Digitally signed by Parimah Oormazdi Date: 2023.01.26 14:51:30 -05'00'
Additional Inspector(s) Parimah Oormazdi (741672)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 5-6, 9-10, 2023

The following intake(s) were inspected:

- Intake: #00004805 - related to a medication incident
- Intake: #00014861 - related to injury of unknown cause

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

Infection Prevention and Control
Resident Care and Support Services
Medication 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 home issued, April 2022, by the Director was implemented in accordance with the standard:

Specifically, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, s. 9.1, states that at a minimum Additional Precautions shall include Point-of-Care signage indicating that enhanced IPAC control measures are in place. The licensee failed to remove the droplet contact precautions signages from two different residents' rooms doors when they were out of isolation and no precautionary signages needed to be posted.

Through initial IPAC observation of the home on January 05, 2023, it was observed that a signage of droplet contact precautions was posted on two different residents' rooms doors at home areas, however there wasn't any Personal Protective Equipment (PPE) supplies caddie hanging on their rooms doors and there wasn't any resident inside those two rooms.

A Registered Nurse (RN) indicated that those two residents were out of isolation and the droplet contact precautions signages should have been removed earlier. They also stated that the posted signages might cause confusion for both staff and residents about isolation status of those two residents.

The droplet contact precaution signages were removed from those two different residents' rooms doors at the point that RN was notified by inspector.

Sources: Initial IPAC observation on January 05, 2023, interview with RN. [741672]

Date Remedy Implemented: January 05, 2023

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 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 a fall prevention intervention that is set out in a resident's plan of care provided to the resident as specified in the plan.

Rationale and Summary:
A resident's care plan indicated that they were at high risk of fall, and they required a fall prevention intervention.

Through an observation of resident while staff were providing care to resident, it was observed that the fall prevention intervention was not provided.

The two Personal Support Workers (PSWs), who provided care to the resident acknowledged that the resident was at risk of fall and the fall prevention intervention should have been provided as per the plan of care.

Failure to provide fall prevention intervention to the resident as set out in their care plan may put them at risk of injury following any fall incident in future.

Sources: Resident's care plan, interview with PSWs, observation of resident during care.

[741672]

COMPLIANCE ORDER CO #001 INFECTION PREVENTION AND CONTROL PROGRAM

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee shall:
1. Review the contents of this compliance order with all PSWs and registered staff in the home.
2. Conduct meal time dining audits of one of the home area's dining room once daily to ensure that staff are reminding and/or assisting residents with completion of appropriate hand hygiene using an alcohol-based hand sanitizer prior to meal service. The date of the audit, the person responsible, and the results of the audit must be documented. If the audit identifies any gaps or omissions, action is taken, and results of the action are documented. The audits are to be completed for a minimum of one month or until such time as there is consistent compliance with hand hygiene.
3. Re-train all PSW staff working at one of the home areas on Additional Precautions including droplet/contact precautions, include appropriate selection, application, removal, and disposal of Personal Protective Equipment (PPE).
4. Maintain a written record of training provided to all PSW staff that includes who attended the training, the content, and the date training was completed.

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) standard for long-term care home issued, April 2022, by the Director was implemented in accordance with the standard:

- s. 10.4 (h), support for residents to perform hand hygiene prior to receiving meals and snacks, and after toileting.

- s. 9.1 (f), additional personal protective equipment (PPE) requirements including appropriate selection, application, removal and disposal.

Grounds
(i) During a dining service observation, at one of the home areas, it was observed that the staff did not provide alcohol-based hand sanitizer to residents prior to serving meals; they provided alcohol free

personal care wipes, to residents.

The home's Hand Hygiene Program policy stated that one of the many indications for when hand hygiene is to be performed is before eating meals. It is also indicated that hand hygiene may be accomplished either by using soap and running water, or an alcohol-based hand rubs.

The home's IPAC lead, Director of Care (DOC) and Environmental service Manager (ESM) confirmed that the personal care wipes that were provided to residents prior to their meals did not contain any alcohol and is not considered as hand sanitizer.

By not supporting residents to sanitize their hands with alcohol based hand sanitizer prior to serving meals, it increased the risk of transmission of infection.

Sources: Home's policy #LTC-CA-WQ-205-02-04, titled Hand Hygiene Program, last revision on September 2022, dining observation, interviews with the IPAC lead, DOC and Environmental Service Manager (ESM).

[741672]

(ii) On January 06, 2023, it was observed that a staff member at one of the home areas did not wear PPE prior to entering a resident 's room that had signage of droplet and contact precautions posted on their room door. The staff member went inside resident's room and stood by their bed side within 2 meters to offer snacks.

The home's Personal Protective Equipment policy indicates that PPE will be used by all employees when entering a room where residents are on Additional precautions (contact droplet/ Contact airborne) as per Routine Practice and Additional Precautions ensuring proper order and techniques for donning and doffing to prevent cross contamination.

Registered Nurse (RN) indicated that the resident was on droplet contact precautions since they had symptoms and suspected for respiratory infection. They stated that staff should wear full PPE prior to entering that resident's room. The IPAC lead confirmed that the expectation was to wear full PPE before entering resident's room who was on droplet contact precautions.

Failure to wear PPE prior to entering resident's room who was on droplet-contact precautions, it increased the risk of infection transmission among staff and residents.

Sources: Policy #LTC-CA-WQ-205-03-05, titled Personal Protective Equipment policy, last revision on October 2022, interview with RN and the IPAC lead, observation of donning/ doffing PPE on January 06, 2023.

[741672]

This order must be complied with by April 17, 2023.

COMPLIANCE ORDER CO #002 INFECTION PREVENTION AND CONTROL PROGRAM

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee shall:
1. Review the contents of this compliance order with Registered Nurse (RN) and screener/ tester staff in the home.
2. Review and re-train a Registered Nurse (RN) staff on universal masking, including the home's procedure "How to Wear a Surgical Mask".
3. Conduct audits of the RN's masking practices on each shift worked. The date of the audit, the person responsible, and the results of the audit must be documented. If the audit identifies any gaps or omissions, action is taken, and results of the action are documented. The audits are to be completed for a minimum of one month or until such time as there is consistent compliance.
4. Educate a screener/ tester staff member on the instructions that are provided on COVID-19 Rapid Antigen Test (RAT) procedure card.
5. Conduct testing audits of the screener/ tester staff's adherence with RAT testing procedures on each shift worked. The date of the audit, the person responsible, and the results of the audit must be documented. If the audit identifies any gaps or omissions, action is taken, and results of the action are documented. The audits are to be completed for a minimum of one month or until such time as there is consistent compliance.
6. Maintain a written record of reviews and training provided to staff that includes who attended the training, the content, and the date training was completed.

The Licensee failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, effective April 27, 2022.

Grounds
(i) Homes must ensure that all staff comply with masking requirements at all times, even when they are not delivering direct patient care, including in administrative areas.

Through initial IPAC observation of the Long-Term Care Home on January 05, 2023, it was observed that an RN did not comply with universal masking requirements. Their mask was not covering their nose while working at the nursing station and making rounds through the home area where other staff and residents were present.

The Long-Term Care Home has posted signage of "How to Wear a Surgical Mask" at the home's entrance door and all home areas which provides step by step instruction to how to wear a medical mask in a way that the nose and mouth are covered properly.

The RN acknowledged that they should have worn the mask properly and their nose should have been covered while they were working on the unit. IPAC lead confirmed that the medical mask should be worn all the time and should fully cover both mouth and nose.

Due to the home not ensuring that the universal masking requirements as set out in the Minister's Directive were followed, there was risk of infection transmission.

Sources: Initial IPAC observation, interviews with RN and IPAC lead, Minister's Directive: COVID-19 response measures for long-term care homes, effective April 27, 2022, home's signage "How to Wear a Surgical Mask".

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(ii) Licensees are required to ensure that the COVID-19 asymptomatic screen testing requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, or as amended, are followed.

On the procedure card of the COVID-19 RAT device, which was used in the home to test visitors and staff prior to entering the home areas, indicated that the results of the test should be read 15 minutes after the drops of the extracted solution added on the test device.

On January 06, 2022, it was observed that a visitor was tested for COVID-19 rapid antigen test upon entry at testing station, however they were allowed to enter the home areas within 10 minutes after the extracted solution drops were added on the test device, and their test device was discarded as soon as they entered the home areas.

A staff member, who was responsible for testing staff and visitors, acknowledged that they didn't follow the instructions on COVID-19 procedure card. IPAC lead stated that the manufacturer's instruction had been misread and the waiting time to read the results is more than 15 minutes. They confirmed that all the screener/ tester staff should follow the manufacturer's COVID-19 testing instructions.

By not following the manufacturer's instructions, there was a risk of a false negative result and spreading infection among staff and residents.

Sources: Interview with screener/ tester staff, interview with IPAC lead, observation of testing and screening staff and visitors, RAT procedure card.

[741672]

This order must be complied with by April 17, 2023.

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.