

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

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119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
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Bureau régional de services de
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119, rue King Ouest 11^{ième} étage
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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
Oct 29, 2021	2021_926267_0004	000653-21, 007684- 21, 007800-21, 009007-21, 016189-21	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 Brant Centre Long Term Care Residence
1182 Northshore Blvd. East Burlington ON L7S 1C5

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

JOBBY JAMES (694267), JESSICA PALADINO (586), PARMINDER GHUMAN (706988)

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): October 13, 14, 15, 18-22, 25, 2021.

The following Critical Incident System (CIS) inspections were completed concurrently:

Log# 007800-21 (CIS# 2900-000012-21) and Log# 009007-21 (CIS# 2900-000013-21) related to falls with injury.

Log# 007684-21 (CIS# 2900-000011-21) and Log# 016189-21 (CIS# 2900-000021-21) related to abuse.

Log #: 000653-21 (CIS# 2900-000003-21) related to an unexpected death.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Maintenance Manager (MM), Clinical Quality Coordinator (CQC), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), family members and residents.

During the course of the inspection, the inspector(s) toured the home, completed an IPAC checklist, observed resident care and meal service and reviewed camera footage, relevant policies and procedures, internal investigation notes and coroner's report.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Infection Prevention and Control

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- 3 WN(s)**
- 1 VPC(s)**
- 1 CO(s)**
- 0 DR(s)**
- 0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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 all staff participated in the implementation of the IPAC program.

A) An RPN was observed providing care to a resident in their room who required additional precautions. The staff member was not wearing any PPE and had taken the treatment cart inside of the room.

The DOC confirmed that as per policy and IPAC best practices, treatment carts should not be taken into rooms on additional precautions and that staff were required to wear appropriate PPE at all times when providing care. (694267).

B) A PSW entered a resident room who was on additional precautions multiple times without performing hand hygiene and without wearing any PPE. The room had additional precaution and hand hygiene signage clearly visible on the door.

By not using the appropriate PPE, the two staff members increased the risk of transmission of infection.

Sources: Observation of the resident home areas, review of Infection Control Manual policy# LTC-CA-WQ-205-03-07 and interviews with staff. [s. 229. (4)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

- s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,**
- (a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).**
 - (b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).**
 - (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).**

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident, who demonstrated responsive behaviours, had strategies implemented to respond to these behaviours.

The resident's documented plan of care included interventions to manage the resident's resistance to care.

The resident was noted to have an injury. The internal investigation by the LTC home, and the camera footage revealed that the staff did not follow the interventions documented in the care plan.

Failure to follow the resident's interventions resulted in injury to the resident.

Sources: DOC's investigative notes; care plan and electronic health record of the resident; and interviews with staff. [s. 53. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.

**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6.
Plan of care**

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's plan of care included clear directions to staff and others who provide direct care to the resident.

The resident tripped on their care delivery item and fell. The resident sustained an injury resulting in transfer to the hospital and subsequent surgery.

As a result, the resident's documented plan of care was updated to include the proper handling of the care delivery item to prevent recurrence. Interviews with the staff confirmed that the directions were not clear and could have been more specific. The DOC confirmed that the intervention did not provide clear direction to the staff on how to handle the care delivery item.

Failing to provide clear directions to the staff on how to handle the resident's care delivery item could result in resident's injury.

Sources: CIS, observation of the resident's room, review of the progress notes, care plan, and interviews with staff. [s. 6. (1) (c)].

Issued on this 1st day of November, 2021

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

Original report signed by the inspector.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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) : JOBBY JAMES (694267), JESSICA PALADINO (586),
PARMINDER GHUMAN (706988)

Inspection No. /

No de l'inspection : 2021_926267_0004

Log No. /

No de registre : 000653-21, 007684-21, 007800-21, 009007-21, 016189-
21

Type of Inspection /

Genre d'inspection: Critical Incident System

Report Date(s) /

Date(s) du Rapport : Oct 29, 2021

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 Brant Centre Long Term Care Residence
1182 Northshore Blvd. East, Burlington, ON, L7S-1C5

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : Biljana Cekar Spasic

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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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:

Order(s) of the Inspector**Ordre(s) de l'inspecteur**

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

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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 comply with r. 229 (4) of Ontario Regulation 79/10.

The licensee must:

1. Provide re-training to a specified PSW and a specified RPN on Infection Prevention and Control (IPAC) practices, specifically regarding hand hygiene and appropriate use of Personal Protective Equipment (PPE) for additional precautions;
2. Maintain a record of this training, including the training material provided, the date and a signature of the persons who attended; and,
3. Audit staff, including the two specific staff noted above, on the appropriate use of PPE following IPAC practices in accordance with the licensee's policy. At least one audit must be completed on different home areas each day, during different shifts, until at least November 29, 2021, or until no further concerns arise. A record of the audits must be kept for Long-Term Care Home (LTCH) Inspector review.

Grounds / Motifs :

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

1. The licensee has failed to ensure that all staff participated in the implementation of the IPAC program.

An RPN was observed providing care to a resident in their room who required additional precautions. The staff member was not wearing any PPE and had taken the treatment cart inside of the room.

The DOC confirmed that as per policy and IPAC best practices, treatment carts should not be taken into rooms on additional precautions and that staff were required to wear appropriate PPE at all times when providing care. (694267). (706988)

2. A PSW entered a resident room who was on additional precautions multiple times without performing hand hygiene and without wearing any PPE. The room had additional precaution and hand hygiene signage clearly visible on the door.

By not using the appropriate PPE, the two staff members increased the risk of transmission of infection.

Sources: Observation of the resident home areas, review of Infection Control Manual policy# LTC-CA-WQ-205-03-07 and interviews with staff. [s. 229. (4)]

Severity: Two staff members on two different home areas were noted without the appropriate PPE when entering and exiting the resident rooms that required additional precautions.

Scope: This was noted as a pattern in the LTCH during multiple IPAC observations.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with O.Reg. s.229 (4) where a Voluntary Plan of Correction (VPC) was issued to the home. (706988). (694267)

**This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :**

Nov 29, 2021

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
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l'article 154 de la *Loi de 2007 sur les
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2007, chap. 8

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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:

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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section 154 of the *Long-Term
Care Homes Act, 2007*, S.O.
2007, c. 8

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2007, chap. 8

**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
438, rue University, 8^e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

Order(s) of the Inspector**Ordre(s) de l'inspecteur**

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

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l'article 154 de la *Loi de 2007 sur les
foyers de soins de longue durée*, L.O.
2007, chap. 8

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 révision
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 29th day of October, 2021

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : Jobby James

Service Area Office /

Bureau régional de services : Hamilton Service Area Office