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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: July 14, 2023

Inspection Number: 2023-1384-0004

Inspection Type:
Complaint
Critical Incident System

Licensee: Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner

Long Term Care Home and City: Chartwell Brant Centre Long Term Care Residence, Burlington

Lead Inspector	**Inspector Digital Signature**
Carla Meyer (740860)	Paola C Meyer Digitally signed by Paola C Meyer Date: 2023.07.14 13:35:59 -04'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 29th-30th, and July 4th-6th, 2023

The following intake(s) were inspected:

- Intake: #00007867 - [CI: 2900-000028-22] - Falls Prevention and Management.
- Intake: #00007871 - [CI: 2900-000029-22] – Medication Management.
- Intake: #00090381 - IL-14380-HA – Prevention of Abuse and Neglect.
- Intake: #00090423 - IL-14420-HA – Prevention of Abuse and Neglect.
- Intake: #00090566 - [CI: 2900-000012-23] – Residents' Rights and Choices.

The following intake(s) were completed during this inspection: intake: #00005566 - [CI: 2900-000002-22], intake: #00006882 - [CI: 2900-000006-22], intake: #00009225 [CI: 2900-000030-22] were all related to Falls Prevention and Management.

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

Falls Prevention and Management
Infection Prevention and Control
Medication Management
Prevention of Abuse and Neglect
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Administration of drugs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee failed to ensure that an identified staff administered a drug to residents in accordance with the directions for use specified by the prescriber.

Rationale and Summary

The Director of Care (DOC) informed the inspector that during a week in July of 2022, a COVID-19 vaccination clinic was held for the residents. Public Health (PH) had provided the home with Moderna vaccines which directed the home to administer 0.5 milliliters (ml), intramuscularly to the residents.

The DOC stated that the home was made aware on a specified date in August 2022 by PH that an error was identified related to the dosage administered during this time based on PH's audit. The DOC acknowledged that the identified staff administered 0.25 ml of Moderna vaccine to 45 residents instead of the prescribed 0.5 ml. Clinical records confirmed that the wrong dose were administered.

By failing to administer medications to residents in accordance with the directions for use specified by the prescriber, residents were placed at risk of harm of adverse drug reactions and COVID-19.

Sources: Interview with the DOC, CI: 2900-000029-22, and residents clinical records.

[740860]