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: February 21, 2023	
Inspection Number: 2023-1318-0002	
Inspection Type: 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 Wenleigh Long Term Care Residence, Mississauga	
Lead Inspector Kehinde Sangill (741670)	**Inspector Digital Signature** Kehinde U Sangill Digitally signed by Kehinde U Sangill Date: 2023.02.21 13:35:23 -05'00'
Additional Inspector(s) Inspector (596) Theresa Berdoe-Young was also present during this inspection.	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 7-10, 2023

The following intake was inspected:

- Intake: #00016504 - 2833-000018-22 - Unwitnessed fall resulting in an injury

The following intake was completed in this inspection:

- Intake: #00013439 - 2833-000016-22 - Unwitnessed fall resulting in an injury.

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 (7) 11.

The licensee has failed to ensure that the infection prevention and control (IPAC) lead carried out their responsibilities related to the Hand Hygiene (HH) program in accordance with "IPAC Standard for Long-Term Care Homes, April 2022" (IPAC Standard).

Specifically, the IPAC lead failed to ensure that the HH program included access to 70-90% Alcohol-Based Hand Rub (ABHR) as was required by Additional Requirement 10.1 under the IPAC Standard, and that expired ABHR were not being used in the home.

Rationale and Summary

In one Resident Home Area (RHA), an expired bottle of ABHR was observed. The bottle expired on May 31, 2022. On the same day, a second bottle of the same brand of expired ABHR was found in another area of the home. Two staff were notified of the observation.

Staff verified that the product was expired, and it would be discarded. The expired bottles were removed on the same day.

No other expired ABHR were observed during the remainder of the inspection.

There was low risk to residents as non-expired ABHR was available for use.

Sources: Inspector #741670's observations; interview with relevant staff [741670]

Date Remedy Implemented: February 7, 2023

WRITTEN NOTIFICATION: Infection prevention and control

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (7) 11.

The licensee has failed to ensure that the IPAC lead carried out their responsibilities related to the HH program.

The IPAC Lead failed to ensure that a HH program was in place in accordance with the IPAC Standard. Specifically, the IPAC Lead did not ensure that the HH program included 70-90% ABHR as required by Additional Requirement 10.1 under the IPAC Standard.

Rationale and Summary

In one unit dining room, staff members were observed assisting residents with HH using "Prevail Fragrance Free Washcloth". A Registered Practical Nurse (RPN) indicated that a second product, "Personal Care Wipes" was also being used for resident HH before meals. Both products were non-alcohol based.

The "Personal Care Wipes" were also found in another unit dining room. A Registered Nurse (RN) indicated that the product was used for resident HH prior to meals.

The IPAC lead acknowledged that hand sanitizers with 70% alcohol should have been used for residents' HH.

The home's HH policy stated that HH may be accomplished by using soap and running water or an ABHR.

The use of non-alcohol based wipes without antimicrobial properties increased the risk of infectious disease transmission.

Sources: Dining rooms observations; review of product ingredients and IPAC Standard for long-term care homes (LTCHs), dated April 2022; and interviews with RPN, RN and IPAC Lead.[741670]

WRITTEN NOTIFICATION: Directives by minister

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The Licensee has failed to ensure that a policy directive that applied to the LTCH, the Minister's Directive: COVID-19 response measures for LTCHs, was complied with.

The Directive required the licensee to conduct regular IPAC audits in accordance with the "COVID-19 Guidance Document for Long-Term Care Homes in Ontario". The document required that homes complete IPAC audits every two weeks when not in an outbreak.

Rationale and Summary

The home completed two IPAC audits 19 days apart, which exceeded the two weeks intervals required when a home was not in an outbreak.

The IPAC Lead acknowledged that the self-audits were not completed at the required intervals.

Failure to complete IPAC self-audits at the required intervals increased the risk of IPAC concerns not being identified in a timely manner.

Sources: Review of Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022 and COVID-19 Guidance document for long-term care homes in Ontario, updated December 23, 2022, LTCH's IPAC self-audits; interview with IPAC Lead. [741670]

WRITTEN NOTIFICATION: Resident Records

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 274 (b)

The licensee has failed to ensure that a resident's written record was kept up to date at all times.

Rationale and Summary

A resident's temperature was documented under the name of the previous occupant of their room over a three-week period. No alternative record was provided for the resident's temperature within this time.

The RPN acknowledged that the resident's name was not added to the temperature tracking record upon admission.

The IPAC Lead indicated that it was the responsibility of the unit nurse to verify the accuracy of the names of residents on the temperature tracking record.

Failure to ensure up to date resident record may lead to delay in assessment.

Sources: Review of resident COVID-19 Surveillance Tracking log; interviews with RPN and IPAC lead. [741670]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the IPAC lead carried out their responsibility related to routine practices and additional precautions.

The IPAC lead failed to ensure that additional precautions were followed in accordance with the IPAC Standards. Specifically, the IPAC lead did not ensure the proper use of Personal Protective Equipment (PPE), including appropriate application and removal as is required by Additional Requirement 9.1 (d) under the IPAC Standard.

Rationale and Summary

A Personal Support Worker (PSW) was observed pulling a laundry bin down a hallway while wearing gloves, a gown and a mask that were used for the care of a resident on contact precautions. The PSW acknowledged that PPE used for resident care should not be worn in the hallway.

The following day, the same PSW did not practice donning and doffing sequence of PPE. The PSW wore two pairs of gloves during resident care. The droplet and contact precautions signage on the resident's door showed appropriate sequence for donning and doffing of PPE. The PSW acknowledged that only one pair of gloves was required for resident care.

On the same day, a screener was observed wearing the same PPE they used for rapid testing to conduct screening of visitors entering the building. The screener acknowledged that the PPE should be removed before screening visitors.

The IPAC lead acknowledged that PPE should be removed after each rapid testing. The IPAC lead noted that one pair of gloves was required for resident care and that PPE used during care should be removed and discarded in the room where care was provided.

The home's PPE policy stated that staff should remove and immediately dispose of PPE when the interaction for which the PPE was used has ended. The policy indicated that staff should not wear more than one pair of gloves at a time while providing care.

Failure of staff to adhere with PPE requirements may compromise the long-term care home's IPAC efforts.

Sources: Observations related to the home's IPAC practices; interviews with a screener, PSW and IPAC Lead; review of home PPE Policy (LTC-CA-WQ-205-03-05 Revision Dates: November 2017, November 2019, October 2022) and IPAC standards. [741670]