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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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
Nov 8, 2021	2021_833763_0020	011162-21, 011163-21	Follow up

Licensee/Titulaire de permis

Chartwell Master Care LP
7070 Derrycrest Drive Mississauga ON L5W 0G5

Long-Term Care Home/Foyer de soins de longue durée

Chartwell Gibson Long Term Care Residence
1925 Steeles Avenue East North York ON M2H 2H3

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

IANA MOLOGUINA (763)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): October 20-22, 25-27, 2021.

The following intakes were completed during this Follow up inspection:

- Log #011163-21 was related to Compliance Order (CO) #001 from inspection #2021_595110_0007 regarding s. 6. (7), with a Compliance Due Date (CDD) of September 23, 2021.
- Log #011162-21 was to follow-up to CO #001 from inspection #2021_595110_0008 regarding r. 71. (4), with a CDD of September 23, 2021.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Physiotherapist (PT), Registered Dietitian (RD), Registered Nurse (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), housekeeping staff, food service staff, and residents.

During the course of this inspection, the inspector reviewed residents' clinical records and conducted observations, including staff-resident interactions, meal observations and resident care provision.

The following Inspection Protocols were used during this inspection:
Dining Observation
Infection Prevention and Control
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2021_595110_0007	763
O.Reg 79/10 s. 71. (4)	CO #001	2021_595110_0008	763

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. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that PSW #109 used proper techniques to assist a resident when they lowered the resident's head of the bed immediately after feeding.

Record review indicated that the resident required a texture modified diet and was at risk for intake-related illness due to their diagnosis. They often ate in bed and required assistance.

PSW #109 was observed feeding the resident on several occasions while the resident was in bed. They brought the resident's head of the bed up and helped them consume a drink. PSW #109 then lowered the head of the bed flat before leaving their room. They acknowledged that they should have left the head of the bed elevated after assisting the resident with eating or drinking to decrease choking risk.

The home's registered dietitian indicated that residents needed to be kept upright for about 30 minutes after eating or drinking to decrease the risk of choking, and education on this topic was recently provided to nursing staff.

Sources: resident clinical records (care plan, PointClickCare profile); "Hydration and offering fluids" educational material, Seasons Care Dietitian Network; observations; staff interviews (PSW #109, RD #113). [s. 73. (1) 10.]

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 in ensuring that staff use proper techniques to assist residents during feeding, to be implemented voluntarily.

WN #2: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was reassessed and the plan of care revised when care set out in the plan was no longer necessary.

The resident was at risk for falls and had several interventions implemented to manage their risk in their plan of care.

Inspector #763 observed the resident while they were using their assistive device. One of the interventions included in their plan of care to manage their falls risk was not in use. Staff indicated that the indicated intervention was no longer required to manage the resident's falls risk and that they forgot to update the resident's plan of care with this information.

Sources: resident clinical records (PointClickCare profile, progress notes, care plan), observations, staff interviews (PSW #107, RN #108, and DOC #101). [s. 6. (10) (b)]

Issued on this 10th day of November, 2021

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

Original report signed by the inspector.