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 |
|---|---|---|---|
| Jun 29, 2021 | 2021_595110_0007 | 009249-20, 000316-21, 006473-21 | Critical Incident System |

### 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

DIANE BROWN (110)

## 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): May 13, 14, 17, 20, 25-28, 2021.**

**The following critical incidents were inspected:**
**Log #009249-20 related to an allegation of staff to resident abuse.**
**Log #000316-21 related to a resident fall resulting in a significant change in status.**
**Log #006473-21 related to an allegation of resident to resident abuse.**

**The LTC home's infection prevention and control practices were also observed and inspected.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Registered Nurse, physiotherapist, personal support workers, housekeeping aide.**

**During the course of this inspection the Inspector observed residents, toured home areas, reviewed health records and relevant home policy and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Infection Prevention and Control**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. The licensee failed to ensure the care set out in the plan of care was provided to a resident as specified in the plan.

A Critical Incident (CIS) was reported to the Ministry of Long-Term Care alleging staff to resident abuse. Resident #002 alleged that a PSW abused them during care. A registered staff responding to the resident's distress and allegations observed and assessed an area of altered skin integrity.

Resident #002's plan of care included the provision of two staff for all care related to their responsive behaviors.

An interview with PSW #102, who provided care to the resident, on the day of the incident, revealed the resident had exhibited responsive behaviors during care. The PSW confirmed they had not asked a second PSW to assist them and subsequently had not followed the resident's plan of care.

The licensee failed to ensure two staff were present during care as specified in their plan of care.

Sources: resident care plan, health records and staff interviews including PSWs #100, #101 and #102. [s. 6. (7)]

2. A CIS was reported to the Ministry of Long-Term Care alleging resident to resident abuse. The allegation reported resident #005 exhibited responsive behaviors towards resident #004, in a common area, that resulted in an injury to resident #004.

Resident #005's plan of care included responsive behaviors towards co-residents. The plan directed staff to monitor them closely in common areas.

Resident #004's plan of care included an identified behavior that was a known trigger to other residents. The plan required staff to redirect the resident away from other residents and from common areas when the behavior was exhibited. Resident #004 was observed exhibiting the behavior during the inspection.

An interview with housekeeper #112 shared that at the time of the incident, from a distance, they observed resident #004, in a common area, interact with resident #005 that resulted in an injury to resident #004. Staff were not present in the area at the time of the residents encounter and altercation. Housekeeper #112 shared that they were unaware of any specific interventions related to resident #004 and #005.

The licensee failed to ensure the care, related to the close monitoring of residents #004 and #005, was provided as specified in their plan of care.

Sources: resident observations, health records including plans of care and staff interviews with PSW #014, #105, RN #103, housekeeping aide #112. [s. 6. (7)]

3. A CIS was submitted to the Ministry of Long-Term Care reporting resident #003's fall with injury and significant change in status.

Resident #003 fell resulting in a significant change in status. A PSW witnessed the resident's fall from a distance as the resident was walking unattended. Three days prior a progress note was written describing the resident walking and how they had entered non-resident areas. Another note, three weeks prior, also identified and described the resident's mobility and risk for falls. Staff interviews further identified the resident at risk of falls.

The resident's plan of care directed one staff to assist the resident with walking.

The licensee failed to ensure resident #003 was provided with one staff assistance when walking as specified in their plan of care.

Sources:plan of care, progress notes, post fall assessment and analysis form, scott fall risk assessment form, physiotherapy referral, assessment and interviews with PSW #104, #105, RN #106 and PT #108. [s. 6. (7)]

***Additional Required Actions:***

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

**Issued on this 14th day of July, 2021**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## 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 foyers de soins de longue durée*, L.O. 2007, chap. 8

**Long-Term Care Operations Division**
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**Inspection de soins de longue durée**

## Public Copy/Copie du rapport public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | DIANE BROWN (110) |
| **Inspection No. / No de l'inspection :** | 2021_595110_0007 |
| **Log No. / No de registre :** | 009249-20, 000316-21, 006473-21 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Jun 29, 2021 |
| **Licensee / Titulaire de permis :** | Chartwell Master Care LP<br>7070 Derrycrest Drive, Mississauga, ON, L5W-0G5 |
| **LTC Home / Foyer de SLD :** | Chartwell Gibson Long Term Care Residence<br>1925 Steeles Avenue East, North York, ON, M2H-2H3 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Autumn Trumbull |

To Chartwell Master Care LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

**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

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**Order # / No d'ordre :** 001

**Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

**Order / Ordre :**

The licensee must be compliant with the LTCHA, s. 6 (7).

Specifically, the licensee must:

1. Provide care as set out in the plan of care to residents #003, #002 and #004.
2. Conduct twice-weekly audits on each resident home area, for a period of one month, following service of this order to ensure:
a. Residents are provided the appropriate assistance with ambulation;
b. Residents are assisted by two staff for personal care as required; and
c. Residents who require close monitoring for responsive behaviors are monitored as per their plan of care.
3. Retain copies of the audits for review by an Inspector.

**Grounds / Motifs :**

1. A Critical Incident (CIS) was reported to the Ministry of Long-Term Care alleging staff to resident abuse. Resident #002 alleged that a PSW abused them during care. A registered staff responding to the resident's distress and allegations observed and assessed an area of altered skin integrity.

Resident #002's plan of care included the provision of two staff for all care related to their responsive behaviors.

An interview with PSW #102, who provided care to the resident, on the day of the incident, revealed the resident had exhibited responsive behaviors during care. The PSW confirmed they had not asked a second PSW to assist them and subsequently had not followed the resident's plan of care.

The licensee failed to ensure two staff were present during care as specified in their plan of care.

Sources: resident care plan, health records and staff interviews including PSWs #100, #101 and #102. [s. 6. (7)]

(110)

2. A CIS was reported to the Ministry of Long-Term Care alleging resident to resident abuse. The allegation reported resident #005 exhibited responsive behaviors towards resident #004, in a common area, that resulted in an injury to resident #004.

Resident #005's plan of care included responsive behaviors towards co-residents. The plan directed staff to monitor them closely in common areas.

Resident #004's plan of care included an identified behavior that was a known trigger to other residents. The plan required staff to redirect the resident away from other residents and from common areas when the behavior was exhibited. Resident #004 was observed exhibiting the behavior during the inspection.

An interview with housekeeper #112 shared that at the time of the incident, from a distance, they observed resident #004, in a common area, interact with resident #005 that resulted in an injury to resident #004. Staff were not present in the area at the time of the residents encounter and altercation. Housekeeper #112 shared that they were unaware of any specific interventions related to resident #004 and #005.

The licensee failed to ensure the care, related to the close monitoring of residents #004 and #005, was provided as specified in their plan of care.

Sources: resident observations, health records including plans of care and staff interviews with PSW #014, #105, RN #103, housekeeping aide #112. [s. 6. (7)]

(110)

3. A CIS was submitted to the Ministry of Long-Term Care reporting resident #003's fall with injury and significant change in status.

Resident #003 fell resulting in a significant change in status. A PSW witnessed the resident fall from a distance as the resident was walking unattended. Three days prior, a progress note was written describing the resident walking and how they had entered non-resident areas. Another note, three weeks prior, also identified and described the resident's mobility and risk for falls. Staff interviews further identified the resident at risk of falls.

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The licensee failed to ensure resident #003 was provided with one staff assistance when walking as specified in their plan of care.

Sources: plan of care, progress notes, post fall assessment and analysis form, scott fall risk assessment form, physiotherapy referral, assessment and interviews with PSW #104, #105, RN #106 and PT #108. [s. 6. (7)]

An Order was made by taking the following factors into account:

Severity: There was actual harm and risk to residents #003, #002 and #004 when care was not provided in keeping with the resident's assessed safety needs and plan of care.

Scope: The scope of this non-compliance was widespread as at least three out of three residents reviewed were impacted.

Compliance History: The licensee has one or more related non-compliance in the last 36 months.

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## 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

(110)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d’ici le :** Sep 23, 2021

## 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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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:

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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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.

## 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
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416-327-7603

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 revision 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
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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 June, 2021**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** DIANE BROWN

**Service Area Office /**
**Bureau régional de services :** Toronto Service Area Office