Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Original Public Report

Report Issue Date September 8, 2022
Inspection Number 2022_1086_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Chartwell Master Care LP

Long-Term Care Home and City
Chartwell Gibson LTCH, North York

Lead Inspector
Reji Sivamangalam (739633)

Inspector Digital Signature
Reji K Sivamangalam
Digitally signed by Reji K Sivamangalam
Date: 2022.09.12 09:23:50 -04'00'

Additional Inspector(s)
Stephanie Luciani (707428)

Inspector Ramesh Purushothaman (741150) was also present during this inspection.

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 22-26 and 29-31, 2022.

The following intake(s) were inspected:

- Intake #012477-22 (Critical Incident System (CIS) #2556-000013-22), #010965-22 (CIS #2556-000010-22), #006671-22 (CIS #2556-000005-22), #020233-21 (CIS #2556-000021-21), #019492-21 (CIS #2556-000020-21), #018014-21 (CIS #2556-000018-21), 017995-21 (CIS #2556-000017-21) and #012633-21 (CIS #2556-000009-21) were related to fall prevention and management.
- Intake #015936-21 (CIS #2556-000013-21, #015305-21 (CIS #2556-000012-21), #011741-21 (CIS #2556-000007-21), #011522-21 (CIS #2556-000006-21), #011262-21 (CIS #2556-000005-21), and #010865-21 (CIS #2556-000004-21) were related to responsive behaviours and resident-to-resident altercations.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect

- Responsive Behaviours

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#01 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that a resident's call bell was attached to their bed within reach as per the resident's plan of care.

A resident was required to have their call bell button attached to their bed and within reach as a fall prevention intervention. The resident's call bell was not attached to the bed and was outside of the resident's reach.

A staff member attached the call bell to the resident's bed within their reach after it was brought to their attention by the inspector.

Sources: Observation, Resident's care plan, Interview with staff.

Date Remedy Implemented: August 23, 2022 [739633]

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#02 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 staff performed hand hygiene before and after resident and resident environment contact as required by Routine Practices, specifically 9.1 (b), included in the Infection Prevention and Control (IPAC) standard.

Rationale and Summary

(a) A staff member was observed exiting a resident's room with a soiled waste bag. The staff member discarded the soiled waste bag, did not perform hand hygiene and then touched the clean linen cart in the hallway.

(b) A staff member was observed entering a resident's room and did not perform hand hygiene prior to assisting the resident in their wheelchair to the dining room for lunch service.

(c) A staff member was observed assisting a resident to the dining room in their wheelchair and did not perform hand hygiene after coming into contact with the resident's environment. The staff member then began to pour beverages for lunch service.

(d) A staff member was observed assisting a resident into the dining room in their wheelchair and did not perform hand hygiene after coming into contact with the resident's environment. The staff member then assisted a second resident in their wheelchair to the dining room.

The home's policy titled "Hand Hygiene Program" directed staff to perform hand hygiene as per the four moments of hand hygiene: before initial contact with the resident or resident environment, after bodily fluid exposure risk (after handling waste), and after resident or resident environment contact.

The Infection Prevention and Control (IPAC) Lead acknowledged that staff were to perform hand hygiene before and after coming into contact with a resident or resident's environment, and in between assisting residents.

Failure to ensure staff performed hand hygiene as required by routine practices increased the risk of transmission of infection.

Sources: Observations, review of the home's Hand Hygiene Policy and interview with the IPAC Lead.

[707428]

WRITTEN NOTIFICATION PREVENTION OF ABUSE AND NEGLECT

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 19 (1)

The licensee has failed to ensure that resident #004 was protected from physical abuse by resident #005.

In accordance with the definition identified in section 2 (1) of Ontario Regulation 79/10, "physical abuse" means the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary

Resident #005 had a history of responsive behaviours prior to their admission to the home. As part of the admission assessment, resident #005 was identified as having a history of two different specified responsive behaviors.

On a specific date, Resident #005 was observed striking resident #004 after an altercation occurred outside resident #005's bedroom. Resident #004 sustained injury as a result of the altercation.

A staff member witnessed the altercation and noted that resident #004 was injured at the time of the incident. The Director of Care (DOC) confirmed that physical abuse had occurred causing resident #004 to be injured by resident #005.

Sources: CIS report, residents' clinical records and progress notes, and interviews with staff and the DOC.

[707428]

WRITTEN NOTIFICATION PLAN OF CARE

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 6 (10) (b)

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when interventions for fall prevention and safety were no longer necessary.

Rationale and Summary:

The resident required staff to apply a device to the resident's mobility device as a fall prevention and management intervention.

Upon observation, the above-mentioned device was not in place on the resident's mobility device.

Staff members confirmed that the device was no longer necessary for resident's fall prevention and safety since their care needs had changed.

A staff member acknowledged that the resident's plan of care was not revised when the above-mentioned device was no longer required by the resident.

Not revising the resident's plan of care when the resident's care needs changed increased the risk that direct care staff use inappropriate fall prevention and safety interventions.

Sources: Observations, Resident's written care plan, Interview with staff.

[739633]

WRITTEN NOTIFICATION PLAN OF CARE

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 6 (4) (b)

The licensee has failed to ensure that staff and others involved in the different aspect of the care of a resident collaborated with each other in the implementation of fall prevention interventions.

Rationale and Summary:

After a fall, a post-fall analysis determined the resident's footwear was one of the root causes of their fall and identified wearing closed shoes as an intervention for preventing further falls.

The resident had a fall on a later date, sustained an injury and required hospitalization. Post-fall analysis identified that the resident was not wearing closed footwear at the time of the fall.

The staff member acknowledged that the fall prevention intervention identified in the post-fall analysis was not included in the plan of care and was not communicated to the staff.

Failure to collaborate in the implementation of resident's footwear as a fall intervention, caused continued risk of fall and injury.

Sources: Resident's care plan, progress notes, Interview with staff.
[739633]