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
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002
torontodistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: February 2, 2023

Inspection Number: 2023-1086-0002

Inspection Type:
Critical Incident System

Licensee: Chartwell Master Care LP

Long Term Care Home and City: Chartwell Gibson Long Term Care Residence, North York

Lead Inspector	**Inspector Digital Signature**
Nira Khemraj (741716)	Niranjani Khemraj Digitally signed by Niranjani Khemraj Date: 2023.02.06 12:10:07 -05'00'

Additional Inspector(s)
Maya Kuzmin (741674)
Inspector Adam Dickey (643) was present during this inspection as an assessing mentor

INSPECTION SUMMARY

The Inspection occurred on the following date(s): January 26, 27, 30 and 31, 2023.

The following intake(s) were inspected:

- Intake: #00015887 [2556-000030-22]- Fall resulting in injury and hospitalization.
- Intake: #00018046 [2556-000002-23]- Alleged abuse.

The following intakes were completed:

- Intake: #00013998 [CI:2556-000026-22]- Fall resulting in injury and hospitalization.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
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)
FLTCA, 2021, s. 6 (1) (a)

The licensee has failed to ensure that the planned care intervention of a fall prevention device was included in a resident's written plan of care.

Rationale and Summary
The resident had a falls prevention device in place as a fall intervention. Personal Support Workers (PSW) #103 and #111 indicated the falls prevention device had been in place for approximately one month. Registered Nurse (RN) #110 acknowledged the falls prevention device was not included in the resident's written plan of care. The plan of care was revised to include this intervention as a trial.

Sources: Resident's care plan; interview with PSW #103, PSW #111 and RN #110.

Date remedy implemented: January 29, 2023.
[741674]

NC #002 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 program.

The IPAC lead failed to ensure that that there is in place a hand hygiene program in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022". Specifically, the IPAC lead did not ensure the hand hygiene program includes 70-90% alcohol-based hand rub as is required by Additional Requirement 10.1 under the IPAC Standard.

Rationale and Summary
During observations on the initial tour, a wall mounted alcohol-based hand rub (ABHR) near a resident room was noted with an expiry date of November 2022. Environmental manager #106 stated the delivery with ABHR was arriving that day and it would be replaced.

IPAC lead # 102 acknowledged that expired ABHRs should not be on the units and that housekeeping checks and replaces them when needed. During observations on January 27, 2023, the identified expired ABHR was replaced.

The risk to residents was low and the identified expired ABHR product was replaced.

Sources: Observations and interview with IPAC lead #102

Date remedy implemented: January 27, 2023.
[741716]

WRITTEN NOTIFICATION: Retraining

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)

The licensee has failed to ensure that the persons who have received training under subsection (2) received retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

Rationale and Summary
According to the home's training records for 2022, PSW #112 and #113 did not complete annual retraining on the home's policy to promote zero tolerance of abuse and neglect of residents. In an interview with the Associate Director of Care (ADOC) #109, they confirmed all staff are to annually complete the education and acknowledged that PSW #112 and #113 failed to do so.

Due to PSW #112 and #113 not completing the required annual education, this may have led to an increased risk of harm to residents.

Sources: Training records and interview with ADOC #109.
[741716]