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: June 6, 2024	
Inspection Number: 2024-1086-0001	
Inspection Type: Complaint Critical Incident	
Licensee: Chartwell Master Care LP	
Long Term Care Home and City: Chartwell Gibson Long Term Care Residence, North York	
Lead Inspector Cindy Cao (000757)	**Inspector Digital Signature** Cindy Cao Digitally signed by Cindy Cao Date: 2024.06.07 12:02:29 -04'00'
Additional Inspector(s) Ann McGregor (000704)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 10, 13-17, 21-24, 27-30, 2024

The following intake(s) were inspected:

- Intake: #00109049/Critical Incident (CI) #2556-000002-24 - related to late reporting of a disease outbreak
- Intake: #00110282/CI #2556-000003-24 - related to prevention of abuse and neglect
- Intake: #00110344 /CI #2556-000004-24 - related to unknown cause of injury sustained by a resident

- Intake: #00113250 and intake: #00113286 - complaints related to on-going concerns with the elevators in the home and a resident trapped in elevator for 1.5 hours
- Intake: #00115961/CI #2556-000008-24 - related to fall prevention and management

The following intake(s) were completed in this CI inspection:

- Intake: #00116019/CI #2556-000009-24 and intake: #00115945/CI #2556-000007-24 - related to disease outbreaks in the home

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

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

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

Rationale and Summary
A resident was assessed to be at risk for falls. The resident's plan of care stated they required a specific device when seated in a wheelchair as part of their fall prevention interventions.

On an occasion, the resident was observed sitting in their wheelchair without the device attached. A Registered Nurse (RN) confirmed the resident did not have the device attached to their wheelchair when the inspector made the observation. The RN indicated that the Personal Support Worker (PSW) should have applied the device for the resident when the resident was seated in the wheelchair as per the care plan.

Both the RN and the Director of Care (DOC) acknowledged that the device should have been applied when the resident was seated in the chair.

Failure to apply the specific put the resident at risk for injuries and a delayed staff response.

Sources: Observation made on a specific date, a resident's clinical records, interviews with staff.
[000757]

WRITTEN NOTIFICATION: Doors in a home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee failed to ensure that all doors leading to non-resident areas were kept locked when unsupervised.

Rationale and Summary
Observations conducted during the inspection showed three doors led out to a non-residential area on the first floor north end of the home were unlocked when not supervised by staff.

A RN and the Environmental Service Manager (ESM) stated that the doors led out to a non-residential area should have been locked when not supervised by staff.

Failing to ensure that doors were kept locked when unsupervised posed a risk to the safety of residents.

Sources: An observation made on May 10, 2024; and interviews with staff. [000704]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee failed to ensure that the Director was immediately informed of an outbreak of disease of public health significance.

Rationale and Summary:
On February 12, 2024, public health declared a confirmed a Respiratory Syncytial Virus (RSV) outbreak. The Licensee reported the outbreak to the Director on February 13, 2024.

The Infection Prevention and Control (IPAC) Lead stated that the confirmed outbreak declared by public health should have been reported immediately, and confirmed it was reported a day late.

Failure of the home to immediately report the confirmed RSV outbreak to the Director may have delayed the Director in responding to the incident.

Sources: A Critical Incident System report, the Home's outbreak record, Public Health communication and interview with the IPAC Lead.
[000704]