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

Original Public Report

Report Issue Date: August 09, 2024

Inspection Number: 2024-1086-0003

Inspection Type:
Critical Incident

Licensee: Chartwell Master Care LP

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 31, 2024 and August 1, 2, 2024

The following intake(s) were inspected:

- Intake: #00118030/Critical Incident (CI), related to a disease outbreak and;
- Intake: #00119477/CI, related to an environmental emergency.

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

Infection Prevention and Control
Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 1.
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): 1. An emergency within the meaning of section 268, including fire, unplanned evacuation or intake of evacuees.

The licensee has failed to immediately inform the Director of a fire emergency which required an unplanned evacuation of residents.

Rationale and Summary

The home submitted a critical incident (CI) report related to a fire emergency that occurred on one resident home area (RHA).

The home notified the Director through the Ministry of Long-term Care's (MLTC) after-hours number approximately eight hours after the incident.

A Registered Practical Nurse (RPN) who oversaw the emergency acknowledged that the Director was not immediately notified.

Delay of reporting to the Director may have impacted the effectiveness of the home's management of critical incidents.

Sources: Review of MLTC after-hours number report, CI report and interview with a

RPN.

WRITTEN NOTIFICATION: EMERGENCY PLANS

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (6)
Emergency plans
s. 268 (6) The licensee shall ensure that the communications plan referred to in paragraph 3 of subsection (5) includes a process for the licensee to ensure frequent and ongoing communication to residents, substitute decision-makers, if any, staff, volunteers, students, caregivers, the Residents' Council and the Family Council, if any, on the emergency in the home including at the beginning of the emergency, when there is a significant status change throughout the course of the emergency, and when the emergency is over.

The licensee has failed to ensure that at the beginning of an emergency, substitute decision-makers (SDMs) received communication related to a fire emergency.

Rationale and Summary

The SDMs were initially notified of the emergency approximately eight hours after the incident.

A RPN who oversaw the emergency and the Administrator both acknowledged that the SDMs did not receive communication at the beginning of the emergency.

Failure to communicate to SDMs at the beginning of the emergency prevented them from following up on the well-being of the residents during the emergency.

Sources: Review of CI report and interviews with a RPN and Administrator.

WRITTEN NOTIFICATION: MAINTENANCE SERVICES

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (1) (b)
Maintenance services
s. 96 (1) As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance.

The licensee has failed to ensure that schedules were in place for preventative maintenance related to emergency exit doors.

Rationale and Summary

The CI report of the home's fire emergency indicated that some residents were evacuated in one RHA. At the time of the emergency, Toronto Fire Services (TFS) identified that the mag-lock on an identified stairwell emergency exit door did not open as required for effective emergency exiting.

The Environmental Services Manager (ESM) stated that a third-party fire safety contractor provided regular inspections of exterior building doors as part of the home's preventative maintenance program. The fire safety contractor's inspection report prior to the emergency revealed that the identified stairwell emergency exit door had not been inspected, which was included in the home's preventative maintenance schedule.

Failure to include all emergency exit doors in the home's preventative maintenance schedule placed residents at risk when an emergency requires building evacuation.

Sources: Review of TFS reports, and Fire Safety Contractor report and; interview with ESM.

COMPLIANCE ORDER CO #001 INFECTION PREVENTION AND CONTROL

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1) Ensure that following the resolution of the confirmed Outbreaks on three RHAs identified in two CIs reports, the home's Outbreak Management Team (OMT) and their interdisciplinary infection prevention and control (IPAC) team conduct debrief sessions to assess effective and ineffective IPAC practices in the management of the outbreaks. A summary of findings must be created that makes recommendations for improvements to outbreak management practices, upon

service of this report.

2) Maintain a written record of the debrief sessions conducted and the summary of findings, staff who participated in the debrief sessions, and dates of the debrief sessions and summary of the findings.

3) Re-train personal support workers (PSWs) who work on a particular shift on two RHAs on the appropriate disposal of personal protective equipment (PPE) when care is provided to residents on additional precautions, upon service of this report.

4) Maintain a record of the training conducted including the staff that provided the training, staff that received the training and date(s) of the training.

5) Conduct daily audits on a particular shift for two weeks on two RHAs to ensure that PSWs dispose PPE appropriately when care is provided to residents on additional precautions, upon service of this report.

6) Maintain a record of the audits conducted, the auditor(s), date and times of the audits, results of the audits and any actions taken to address the audit findings.

Grounds

The licensee has failed to ensure the implementation of a standard issued by the Director with respect to IPAC.

(A) The home has failed to ensure that following the resolution of an outbreak, the OMT and the interdisciplinary IPAC team assessed the IPAC practices in the management of the outbreak in accordance with the "IPAC Standard for Long-Term Care Homes, revised September 2023". Specifically, a debrief session was not

conducted following the resolution of an outbreak to assess IPAC practices that were effective and ineffective in the management of the outbreak, as required by Additional Requirement 4.3 under the IPAC Standard.

Rationale and Summary

At the resolution of a previous Acute Respiratory Illness (ARI) Outbreak, the IPAC Lead acknowledged that a debrief session with the home's OMT and the interdisciplinary IPAC Team was not conducted.

Failure to conduct a debrief session following the resolution of their ARI Outbreak may have affected the effectiveness of the home's outbreak management practices.

Sources: Review of CI report and interview with the IPAC Lead.

(B) The home has failed to ensure that additional precautions were followed in accordance with the "IPAC Standard for Long-Term Care Homes, revised September 2023". Specifically, staff did not appropriately dispose of PPE as required by Additional PPE Requirements 9.1 (f) under the IPAC Standard.

Rationale and Summary

Two different types of outbreaks affecting three RHAs occurred at the time of the inspection.

Additional Precautions signage were posted at the entrance doors of four resident rooms. The waste receptacles were not physically distanced from the clean isolation carts that supplied PPE for staff use. The receptacles were touching the sides of the isolation carts. Used isolation gowns were disposed of in a manner

where portions of the gown touched the clean isolation carts. The outbreak line list indicated that two residents in the rooms were confirmed cases in the outbreaks.

The IPAC Hub, conducted an IPAC audit previously and identified the same issue. They recommended that the waste receptacles be physically distanced from the clean isolation carts.

The IPAC Lead and DOC both acknowledged that the used isolation gowns were not disposed of appropriately and there was a risk of infection transmission.

Failure to dispose PPE appropriately placed other residents and staff at risk of infection.

Sources: IPAC Observations on two RHAs; review of outbreak Line List, IPAC Hub Audit, IPAC Standard for Long-Term Care Homes, revised September 2023 and; interviews with the IPAC Lead and DOC.

This order must be complied with by October 11, 2024

COMPLIANCE ORDER CO #002 INFECTION PREVENTION AND CONTROL

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (9)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1) Re-train registered staff working on a particular RHA on the home's process for monitoring and isolating residents who have symptoms indicating the presence of a specified infection, upon service of this report.

2) Maintain a record of the training conducted including the staff that provided the training, staff that received the training and date(s) of the training.
3) Conduct weekly audits for three weeks to ensure that residents that have symptoms indicating the presence of a specified infection are monitored every shift and isolated immediately, upon service of this report.

4) Maintain a record of the audits conducted, the auditor(s), date and times of the audits, resident(s) that were audited, results of the audits and any actions taken to address the audit findings.

Grounds

The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection were monitored and that immediate action were taken to reduce transmission and isolation of two residents.

Rationale and Summary

(A) A resident was a confirmed case during an outbreak. The resident became symptomatic and was not isolated until the following day. Their symptoms of infection were not monitored for two consecutive shifts.

The IPAC Lead indicated that residents who displayed the resident's symptoms of infection should be immediately isolated and monitored every shift.

The Director of Care (DOC) acknowledged that the resident was not immediately isolated and was not monitored for symptoms of infection as required.

There was a risk of infection transmission to other residents and staff when the resident was not isolated immediately.
Failure of staff to monitor the resident's symptoms of infection every shift placed the resident at risk of delayed treatment of their infection.

Sources: Review of a resident's clinical records, Outbreak Line List and; interviews with the IPAC Lead and DOC.

Rationale and Summary

(B) Another resident was a confirmed case during an outbreak. The resident became symptomatic and was not isolated until the following day. Their symptoms of infection were not monitored for one shift.

The IPAC Lead indicated that residents who displayed the resident's symptoms of infection should be immediately isolated and monitored every shift.

The Director of Care (DOC) acknowledged that the resident was not immediately isolated and was not monitored for symptoms of infection as required.

There was a risk of infection transmission to other residents and staff when the resident was not isolated immediately. Failure of staff to monitor the resident's symptoms of infection every shift placed the resident at risk of delayed treatment of their infection.

Sources: Review of a resident's clinical records, Outbreak Line List and; interviews with the IPAC Lead and DOC.

This order must be complied with by October 11, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.