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

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Original Public Report

Report Issue Date: December 1, 2022	
Inspection Number: 2022-1298-0001	
Inspection Type: Critical Incident System	
Licensee: Chartwell Master Care LP	
Long Term Care Home and City: Chartwell Pine Grove Long Term Care Residence, Woodbridge	
Lead Inspector Rodolfo Ramon (704757)	**Inspector Digital Signature** Rodolfo A Ramon Alvarez Digitally signed by Rodolfo A Ramon Alvarez Date: 2022.12.01 13:19:39 -05'00'
Additional Inspector(s) Manish Patel (740841)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 21-25, 2022

The following intake(s) were inspected:

- Intake: #00001325-[CI: 2808-000005-22] related to an injury of unknown cause resulting in significant change
- Intake: #00005015-[CI: 2808-000008-22] related to a fall with injury resulting in significant change
- Intake: #00006743-[CI: 2808-000006-22] related to prevention of abuse and neglect
- Intake: #00007958-[CI: 2808-000011-22] related to a fall with injury resulting in significant change
- Intake: #00011632-[CI: 2808-000014-22] related to an injury of unknown cause resulting in significant change

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

-Infection Prevention and Control
-Prevention of Abuse and Neglect
-Falls Prevention and Management
-Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL LEAD

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 23 (4)

The licensee has failed to ensure that the home had an Infection Prevention and Control (IPAC) lead whose primary responsibility was the home's infection prevention and control program.

Rationale and Summary:
The acting IPAC lead stated that their primary responsibilities were of a charge nurse which included doing rounds with physicians, processing orders and following up on any concern pertaining to the residents. According to the Director of Care (DOC), the IPAC lead role was being filled temporarily with a charge nurse whose primary responsibilities were not IPAC.

Not having an IPAC lead whose primary responsibility was IPAC resulted in the inadequate implementation of the IPAC program, placing residents at risk of acquiring infectious diseases.

Sources:IPAC Job description, interview with IPAC lead #101 and DOC #100.
[740841]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that alleged abuse of resident #001 and #002 was reported to the Director immediately.

Rationale and Summary:
A Critical Incident System (CIS) report was submitted related to alleged abuse of resident #001 and #002. According to the CIS report, the allegation of abuse was made months prior to submission of CIS report.

The DOC confirmed that it was DOC's responsibility to report incidents of alleged abuse to the Director by submitting a CIS report. The Director of Human Resources (DHR), who conducted the investigation, confirmed that the licensee's policy required the Long Term Care Home to notify the director immediately.

Sources: Abuse Allegations and Follow-Up Policy #LTC-CA-WQ-100-05-02 revised in March 2022, CIS report #2808-000006-22, and interviews with the DOC and the DHR.
[740841]