Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 14, 2022	2022_780699_0001	023781-20, 026041-20, 000418-22	Critical Incident System

Licensee/Titulaire de permis

Chartwell Master Care LP
7070 Derrycrest Drive Mississauga ON L5W 0G5

Long-Term Care Home/Foyer de soins de longue durée

Chartwell White Eagle Long Term Care Residence
138 Dowling Avenue Toronto ON M6K 3A6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

PRAVEENA SITTAMPALAM (699)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 6, 7, 10 and 11, 2022.

The following Critical Incident System (CIS) intakes were completed:

-log #023781-20 [CIS 2583-000004-20] related to fall with injury;
-log #026041-20 [CIS 2583-000006-20] related to injury of unknown cause; and
-log #000418-22 [CIS 2583-000001-22] related to infection outbreak.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Food Service Manager (FSM), Housekeeping Aides (HA), Dietary Aides (DA), Registered Practical Nurses (RPN) and Personal Support Workers (PSW).

During the course of the inspection, the inspector observed resident and staff interactions, and reviewed clinical health records, relevant policies and procedures, and other documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (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 (4):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed when the home was declared in outbreak for COVID-19.

The home was declared in outbreak by Public Health. The DOC confirmed that the CIS was submitted two days after the outbreak was declared.

Sources: CIS report #2583-000001-22, and interview with the DOC. [s. 107. (1) 5.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

The inspector conducted a tour of the home and made the following observations:
-a staff member entered an isolated room, with two separate meal trays on a cart. The staff member served the meal tray to one resident and came out of the isolation room with the cart, and went into another isolated room to serve the other tray to a resident;
-a staff assisted a resident in an isolation room with putting on a bib; staff did not wear a gown or gloves, when they assisted the resident; and
-a staff assisted a resident on isolation precautions with their meal; the staff wore a gown, face shield and mask, but did not wear gloves, while they assisted the resident.

Staff indicated that full personal protective equipment (PPE) should be worn when interacting with a resident in a droplet contact isolation room, which includes wearing a surgical mask, face shield, gown and gloves. The DOC indicated that staff should wear the required PPE when assisting the residents. They further indicated that staff should leave the meal cart outside the resident room and only bring in the resident's tray. Taking in resident meal trays into isolation rooms, and not wearing the appropriate PPE when providing assistance to residents placed residents at increased risk for transmission of infection.

Sources: Observations, and staff interviews. [s. 229. (4)]

Issued on this 17th day of January, 2022

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.