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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: April 27, 2023

Inspection Number: 2023-1423-0003

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: Chartwell Master Care LP

Long Term Care Home and City: Chartwell Royal Oak Long Term Care Residence, Kingsville

Lead Inspector	**Inspector Digital Signature**
Christie Birch (740898)	Christie Birch Digitally signed by Christie Birch Date: 2023.04.27 08:24:43 -04'00'

Additional Inspector(s)
Terri Daly (115)
Jennifer Bertolin (740915)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 11, 13, 14, 17, 18, 19, 2023
The inspection occurred offsite on the following date(s): April 20, 2023

The following intake(s) were inspected:
- Intake: #00021418 - Follow-up #: 1 - FLTCA, 2021 - s. 5
- Intake: #00021419 - Follow-up #: 1 - O.Reg. 246/22 - s. 12 (1) 2.
- Intake: #00021420 - Follow-up #: 1 - O.Reg. 246/22 - s. 12 (2)
- Intake: #00019757 - CIS #2939-000006-23 related to falls prevention and management.
- Intake: #00018670 related to a complaint regarding infection prevention and control.

The following intake(s) were completed:
- Intake: #000200004 - CIS # 2939-000007-23 related to falls prevention and management.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1423-0002 related to FLTCA, 2021, s. 5 inspected by Terri Daly (115)

Order #002 from Inspection #2023-1423-0002 related to O. Reg. 246/22, s. 12 (1) 2. inspected by Terri Daly (115)

Order #003 from Inspection #2023-1423-0002 related to O. Reg. 246/22, s. 12 (2) inspected by Terri Daly (115)

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

Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that any standard issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented.

Specifically, the licensee failed to ensure that staff wear a medical mask for the entire duration of their shift indoors as per the Minister's Directive and COVID-19 guidance document for long-term care homes in Ontario.

Rationale and Summary
The Minister's Directive and COVID-19 guidance document for long-term care homes in Ontario state, homes must ensure that all staff, students and volunteers wear a medical mask for the entire duration of their shift indoors regardless of their immunization status and that removal of masks for the purposes

of eating should be restricted to areas designated by the home.

Six staff were observed in a nursing station on the nursing unit not wearing appropriate personal protective equipment (PPE). Those staff acknowledged that the expectation was that they were to wear appropriate PPE unless in a designated staff area.

The Director of Care confirmed that the expectation was that all staff were to wear masks properly unless they were in a designated staff area and that the nursing station was not a designated staff area.

Failure of staff to wear a medical mask at all times while in the home, may have increased the risk of transmission of infection into the home.
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