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

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

Original Public Report

Report Issue Date September 19, 2022
Inspection Number 2022_1075_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Chartwell Master Care LP

Long-Term Care Home and City
Chartwell Elmira, Elmira

Lead Inspector
Katherine Adamski (#753)

Additional Inspector(s)
None

Inspector Digital Signature
Katherine Adamski
Digitally signed by Katherine Adamski
Date: 2022.09.20 09:57:54 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 29 – September 2, 2022

The following intake(s) were inspected:

- Intake # 000275-22 (CIS #2471-000001-22) related to alleged staff to resident abuse

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

- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION PLAN OF CARE

NC#01 Written Notification pursuant to LTCHA, 2007, s. 6 (7)

Non-compliance with: LTCHA, 2007 s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in their plan in relation to responsive behaviors.

Rationale and Summary

Resident #001 had a history of behaviours and their care plan included special instructions for staff when providing care to the resident.

A Personal Support Worker (PSW) did not follow the resident's plan of care, and this resulted in an allegation of staff to resident abuse.

The DOC acknowledged that the PSW should have followed resident #001's plan of care as it related to their behaviours.

When the PSW did not follow resident #001's plan of care, there was no one to intervene and redirect the resident when they exhibited responsive behaviours.

Sources: Resident #001's care plan with revisions, the home's internal investigation including statements from resident #001 and staff, Waterloo Regional Police Report, interviews with resident #001, the DOC and other staff.

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WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL

NC#02 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 IPAC program.

Rationale and Summary
The home's Resident Assessment Instrument Coordinator (RAI-C) who was also the home's designated Acting IPAC Lead, stated that their primary responsibility in the home was as the RAI-C. The RAI-C stated that they dedicated approximately seven and a half hours to IPAC related tasks per week. The RAI-C acknowledged that the home did not have an IPAC Lead, and this made it challenging for the home to complete all the IPAC tasks required by the Ministry of Long-Term Care (MLTC). The RAI-C was not familiar with the IPAC Standard, April 2022.

When the home did not have an IPAC Lead whose primary responsibility was IPAC, it may have contributed to the lack of knowledge regarding the use of PPE, supporting residents with hand hygiene, surveillance tracking and monitoring. This put the residents, staff, and visitors at risk for disease transmission.

Sources: Observations on August 30, 2022, interviews with the DOC, RAI-C/Acting IPAC Lead and other staff, the IPAC Standard (April 2022).

[#753]

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1

Non-compliance with FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that they carried out every operational or policy directive that applies to LTCHs.

Rationale and Summary

According to FLTCA, 2021, s. 184 (3), the licensee was required to implement every operational or policy directive that applies to LTCHs.

The COVID-19 Guidance: Long-Term Care Homes (LTCHs) and Retirement Homes for Public Health Units indicated that the licensee shall conduct symptom assessment of all residents at least once daily, including temperature checks, to identify if any resident has symptoms of COVID-19, including any atypical symptoms as listed in the Management of Cases and Contacts of COVID-19 in Ontario.

Registered Nurse (RN) #108 stated that monitoring of signs and symptoms was either done by nursing staff or delegated to PSW staff. Instructions directed staff to place a check mark in the appropriate box for residents not experiencing signs/symptoms, or the application code for residents who were experiencing signs/symptoms.

A review of the first floor Resident Covid-19 Surveillance Tracking sheets dated August 1 to 28, 2022, showed that on five out of 28 days, staff did not conduct temperature, signs and symptoms surveillance monitoring. Furthermore, the records were not complete on 13 out of 23 days, as staff did not indicate whether or not residents were experiencing any signs or symptoms of COVID-19.

A review of the second floor Resident Covid-19 Surveillance Tracking sheets dated August 1 to 22, 2022, (August 21-28, 2022, could not be located) showed that staff did not indicate whether or not residents were experiencing any signs or symptoms of COVID-19 on 19 out of 20 days.

The RAI-C/Acting IPAC Lead stated it was the floor nurses who were responsible for asking residents about signs and symptoms of infection and that the surveillance sheets were not being monitored for completeness nor being audited. They attributed this as one of the challenges of not having a designated IPAC Lead whose primary responsibility was IPAC.

Sources: Interviews with the RAI-C/Acting IPAC Lead and other staff, the home's Resident Covid-19 Surveillance Tracking sheets (dated August 1-28, 2022), The COVID-19 Guidance: LTCHs and Retirement Homes for Public Health Units (Version 7, dated June 27, 2022).

[#753]

COMPLIANCE ORDER [CO#01] INFECTION PREVENTION AND CONTROL

NC#04 Compliance Order pursuant to FLTCA, 2021, s.154 (1) 2

Non-compliance with: O. Reg. 246/22 s. 102 (2)(b)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22, s. 102 (2)(b)

The licensee must comply with O. Reg. 246/22, s. 102 (2)(b)

Further, the licensee shall:

1. Conduct daily lunchtime dining audits of the first and second floor dining rooms to ensure that staff are reminding and/or assisting residents with hand hygiene. The date of the audit, the person responsible, and the results of the audit must be documented. If the audit identifies any gaps or omissions, action is taken, and results of the action are documented. The audits are to be completed for a minimum of one month or until such time as there is consistent compliance with hand hygiene.

2. Ensure hand hygiene dining audits for both dining rooms are conducted with each COVID-19 Self-Assessment Audit required by the home.

3. Review and re-train Registered Practical Nurse (RPN) #107 on Routine Practices to be used with residents during care to prevent and control the transmission of microorganisms. This includes the appropriate selection, application, removal, and disposal of Personal Protective Equipment (PPE).

4. Review Public Health of Ontario (PHO) Droplet and Contact precautions signage with RPN #107.

5. Maintain a written record of reviews and training provided to RPN #107 that includes who completed the training, the content, and date staff signed off.

Grounds

Non-compliance with O. Reg. 246/22, s. 102 (2)(b)

The licensee has failed to ensure that the standard issued by the Director with respect to IPAC, was implemented.

Rationale and Summary

According to O. Reg. 246/22, s. 102 (2) (b), the licensee was required to implement any standard or protocol issued by the Director with respect to Infection Prevention and Control (IPAC).

1. The IPAC Standard for LTCHs, dated April 2022, section 10.4 (h), indicated that the licensee shall ensure that the hand hygiene program includes support for residents to perform hand hygiene prior to receiving meals and snacks.

The home's Hand Hygiene Program stated that staff were to encourage and assist residents to perform hand hygiene upon arrival, before eating and before leaving their room or clinic area.

A resident who dines on the first floor stated that staff were not consistently reminding or encouraging residents to perform hand hygiene before meals.

On August 30, 2022, 12 of 15 residents entering the second-floor dining area were neither encouraged, reminded, or assisted to perform hand hygiene prior to the meal, despite having a COVID-19 positive resident on the unit.

The home's COVID-19: Self-Assessment Audit Tool for LTCHs and Retirement Home's (dated June 29, 2022), showed that staff were not supporting residents with hand hygiene prior to dining. The Nursing Unit Clerk stated that all staff had been reminded to support residents with hand hygiene after the audit on June 29, 2022.

The RAI-C/Acting IPAC Lead stated that they expected staff to either cue or assist residents with hand hygiene before and after entering the dining room.

When staff did not support residents to perform hand hygiene before they received meals, it increased the risk of possible disease transmission.

2. The IPAC Standard for LTCHs, dated April 2022, section 9.1(d), indicated that the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum, Routine Practices shall include Proper use of Personal Protective Equipment (PPE), including appropriate selection, application, removal, and disposal.

The home's Contact and Droplet Precaution policies and procedures stated the following:

5.12 – For Contact Precautions wear gloves and a gown for activities that involve direct care. Remove gloves and gown, if worn, and perform HH immediately on leaving the room.

5.15 – Wear a mask and eye protection within two meters of a resident on Droplet Precautions.

PHO signage and Regional Infection Control Network, Waterloo-Wellington Droplet and Contact precautions signage was posted on the door of resident #002 and #004's room. The signage directed staff to wear a gown, gloves, mask, and eye protection before entering the room and when they were within two meters of this resident.

A. Resident #002 required contact/droplet precautions for direct care as per signage on their door and their progress notes.

RPN #107 was observed assisting resident #002 with direct care without the proper use of PPE. They acknowledged that they did not don the appropriate PPE to provide direct care to resident #002.

B. Resident #004 required pre-emptive contact/droplet precautions for direct care as per signage on their door and their progress notes.

RPN #107 was observed providing direct care to resident #004 without the proper use of PPE. They acknowledged that they did not don all of the required PPE to provide direct care to resident #004.

Additionally, RPN #107 doffed their soiled PPE in the hallway and disposed of it in the garbage container connected to their medication administration cart, despite a garbage container for soiled PPE being present in the room of resident #004.

When staff did not don and doff PPE correctly with a COVID-19 suspected and confirmed case, it put residents, staff, and visitors at risk of disease transmission.

Sources: Observations of resident #002, #004 and lunchtime dining, **i**nterviews with the RAI-C/Acting IPAC Lead and other staff, interview with resident #003, progress notes for resident #002 and #004, COVID-19 Guidance: Personal Protective Equipment (PPE) for Health Care Workers and Health Care Entities (Version 1.0, dated June 10, 2022), the home's Best Practices for Hand Hygiene Policy (page 10, December 2020), the home's Best Practices for Contact and Best Practices for Droplet Precautions polices and procedures (page 17), the home's COVID-19: Self-Assessment Audit Tool for LTCHs and Retirement Home's (dated June 29, 2022), the IPAC Standard (April 2022).
[#753]

This order must be complied with by: November 4, 2022

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,

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

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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
email: 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.