



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

**Rapport d'inspection
prévue le *Loi de 2007
les foyers de soins de
longue durée***

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Toronto Service Area Office
55 St. Clair Avenue West, 8th Floor
Toronto ON M4V 2Y7

Bureau régional de services de Toronto
55, avenue St. Clair Ouest, 8^{ième} étage
Toronto, ON M4V 2Y7

**Ministère de la Santé et des Soins de
longue durée**

Division de la responsabilisation et de la performance du
système de santé
Direction de l'amélioration de la performance et de la
conformité

Telephone: 416-325-9297
1-866-311-8002

Téléphone: 416-325-9297
1-866-311-8002

Facsimile: 416-327-4486

Télécopieur: 416-327-4486

Licensee Copy/Copie du Titulaire Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
May 24, 25, 26 & June 2, 3, 8, 9, 14, 2011	2011_116_2556_26May134339	Complaint Log #T292-11 T436-11, T530-11
Licensee/Titulaire Chartwell Master Care LP 100 Milverton Drive, Suite 700 Mississauga, ON L5R 4H1		
Long-Term Care Home/Foyer de soins de longue durée The Gibson Long Term Care Centre, 1925 Steeles Avenue East, North York, ON M2H 2H3		
Name of Inspector/Nom de l'inspecteur Saran Daniel-Dodd, Inspector 116 & Tiina Tralman, Inspector 162		
Inspection Summary/Sommaire d'inspection		



The purpose of this inspection was to conduct a complaint inspection regarding air temperatures, licensee response to complainants, notifying Director of complaints, food preferences, lack of opportunity to vote, medication administration, spiritual and religious concerns.

During the course of the inspection, the inspector(s) spoke with: Administrator, Director of Clinical Services, Director of Resident Services, Environmental Manager, Maintenance Supervisor, Food Service Supervisor, Registered Dietitian, Dietary Staff, Registered staff, direct care staff, family members and residents.

During the course of the inspection, the inspector(s): Reviewed resident health record, reviewed home policy related to hot weather environment management, reviewed high risk alert forms, diet lists, program calendar, policy and procedures related to maintenance, policy and procedures related to pastoral programs and services, resident council minutes, daily temperature checklists, physician's orders, observed dining units on second and third floor, and common areas, resident bedrooms.

The following Inspection Protocols were used in part or in whole during this inspection:

- Accommodations Services – Maintenance
- Dignity, Choice and Privacy
- Dining Observation
- Nutrition and Hydration
- Safe and Secure home
- Recreational and Social Activities
- Reporting and Complaints

Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
1 VPC

NON-COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régleur envoyé
CO – Compliance Order/Ordre de conformité
WAO – Work and Activity Order/Ordre: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constitue un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de la Loi de 2007 les foyers de soins de longue durée.

Non-respect avec les exigences sur la Loi de 2007 les foyers de soins de longue durée à trouver. (Une exigence dans la loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with 15. (1) (c) Every licensee of a long-term care home shall ensure that, (c) there is an organized program of maintenance services for the home. 2007, c. 8, s. 15 (1).

Findings:

1. Concern brought forward by family member around air temperature in identified resident's room. Family communicated the air temperature to Registered Staff. Registered Staff could not confirm the date when voice message left for Environmental Manager.
2. Registered Staff stated to inspectors that identified resident was assessed. Resident was not diaphoretic or sweating and every one of the residents in the room denied being hot.
3. The licensee's policy ENV-III-07 entitled 'Maintenance Requisitions' states "refer to emergency contractor contact list located at all RN stations for repair/items requiring attention (heating, cooling, plumbing, maglock, fire alarms, etc) for assistance between the hours of 4:00pm -8:00am.
4. Interviews held with staff members confirmed that the process of communicating issues regarding maintenance concerns was not followed according to home's process.
5. The home has implemented a process to ensure that registered staff has access to the thermostat control for residents rooms as required.

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WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, s. 6 (7). The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c.8, s. 6 (7).

Findings:

1. Staff members did not follow care plan requirements for a resident.
2. Administrator confirmed to inspector's that intervention for an identified resident was not available at identified meals according to the home's letter of response to complainant.

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Additional Required Actions:

VPC - pursuant to the *Licensees Act, 2007*, S.O. 2007, c.8, s.152 (2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O. Reg. 79/10 s. 101. (1) 1. 2. 3. Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an



acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

3. A response shall be made to the person who made the complaint, indicating,
- i. what the licensee has done to resolve the complaint, or
 - ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

Findings:

1. With reference to O. Reg. 79/10 s. 101. (1) 1:
 - The licensee did not provide a letter of response to the complainant within 10 business days of the receipt of the complaint.
2. With reference to O. Reg. 79/10 s. 101. (1) 2 3i:
 - The licensee did not provide a response to the complainant within 10 business days of the receipt of the complaint.
 - The licensee did not provide a letter of acknowledgement within 10 business days to the complainant.

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Signature of Licensee or Representative of Licensee
Signature du Titulaire du représentant désigné

Signature of Health System Accountability and Performance Division
representative/Signature du (de la) représentant(e) de la Division de la
responsabilisation et de la performance du système de santé.

Title:

Date:

Date of Report: (if different from date(s) of inspection).