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

**Toronto District**
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# Original Public Report

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| **Report Issue Date:** July 27, 2023 | |
| **Inspection Number:** 2023-1086-0003 | |
| **Inspection Type:**<br>Critical Incident System | |
| **Licensee:** Chartwell Master Care LP | |
| **Long Term Care Home and City:** Chartwell Gibson Long Term Care Residence, North York | |
| **Lead Inspector**<br>Irish Abecia (000710) | **Inspector Digital Signature**<br>Irish J Abecia Digitally signed by Irish J Abecia Date: 2023.08.04 13:39:49 -04'00' |
| **Additional Inspector(s)**<br>Kehinde Sangill (741670) | |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 13, 14, 17-21, 2023

The following intakes were inspected Critical Incident System (CIS) inspection:

- Intake: #00090390 [CI: 2556-000021-23] - related to a fall
- Intake: #00085135 [CI: 2556-000017-23] - related to an injury of unknown cause
- Intake: #00089805 [CI: 2556-000020-23] and Intake: #00091211 [CI: 2556-000023-23] - related to alleged neglect
- Intake: #00090697 [CI: 2556-000022-23] - related to improper oral care

The following intakes were completed in the CIS inspection:

- Intake: #00019474 [CI: 2556-000006-23] and Intake: #00089641 [CI: 2556-000019-23] - related to falls

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control

Reporting and Complaints
Residents' Rights and Choices
Falls Prevention and Management

# INSPECTION RESULTS

## Non-Compliance Remedied

**Non-compliance** was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

**NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)**
FLTCA, 2021, s. 3 (1) 19. iv.

The licensee has failed to ensure that residents had their Personal Health Information (PHI) within the meaning of the Personal Health Information Protection Act, 2004, kept confidential.

**Rationale and Summary**
A computer screen mounted on the medication cart displayed residents' names and PHI was left unattended in a common area of a Resident Home Area (RHA). There were residents and a family member in the vicinity at the time of the observation.

A Registered Nurse (RN) acknowledged that the screen should have been locked to protect the PHI of residents. The RN immediately hid the screen after the breach was brought to their attention.

**Sources**: Observation in one RHA; interview with RN. [741670]

Date Remedy Implemented: July 14, 2023

**Rationale and Summary**
On another date, a computer screen mounted on the medication cart displayed residents' names and PHI was left unattended in a common area of another RHA. There were no visitors or residents in the immediate vicinity of the screen.

The RN acknowledged that the screen should have been locked to protect the PHI of residents. The RN immediately hid the screen after the breach was brought to their attention.

**Sources**: Observation in a second RHA; interview with RN. [741670]

Date Remedy Implemented: July 21, 2023

**NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)**
FLTCA, 2021, s. 6 (1) (a)

The licensee has failed to ensure that the planned care intervention of a transferring device was included a resident's written plan of care.

**Rationale and Summary**
Two Personal Support Workers (PSWs) were observed transferring a resident. The resident's plan of care indicated that they required a different device for transfer.

A PSW stated that a device had been used to transfer the resident, and a different device was used prior.

An RN acknowledged that the written plan of care did not reflect the change to the transferring device. The resident's written plan of care was updated to reflect the transferring device the resident used.

**Sources**: Observation of resident transfer; resident's clinical record; interviews with staff. [741670]

Date Remedy Implemented: July 14, 2023

## WRITTEN NOTIFICATION: Complaint Procedure

**NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The licensee has failed to ensure that a written complaint that it received concerning the care of a resident was immediately forwarded to the Director.

**Rationale and Summary**
The MLTC received CIS report, related to a complaint regarding a resident's care. The licensee received

the complaint weeks prior.

The licensee's Complaints policy directed the home to immediately report any complaint that alleges harm or risk of harm, including but not limited to physical harm, to one or more residents to the Director.

The Administrator acknowledged that a complaint reported on CIS report was not immediately forwarded to the Director.

**Sources**: CIS report, Complaints Policy; and interview with the Administrator. [741670]

## WRITTEN NOTIFICATION: Oral Care

**NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 38 (1) (a)

The licensee has failed to ensure that oral care for resident included mouth care in the morning.

**Rationale and Summary**
A resident required assistance with oral care. The care plan directed staff to provide oral care in the morning and at bedtime at a minimum.

Over a period of time, the Point of Care (POC) documentation indicated the provision of oral care after lunch on multiple occasions.

A PSW stated that oral care was not provided for the resident until after lunch on most days due to time constraints.

An RN and the Assistant Director of Care (ADOC) stated that staff are required to provide morning oral care before or after breakfast. The ADOC stated that PSWs are expected to inform the charge nurse if difficulties with time management interferes with morning care, including oral care.

Staff's failure to consistently provide oral care to a resident in the morning may have compromised their oral health.

**Sources**: Review of resident's clinical record, home's investigation notes, CIS report; interviews with staff. [741670]

## WRITTEN NOTIFICATION: Skin and wound care

**NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that a resident exhibiting altered skin integrity is reassessed at least weekly by a member of the registered nursing staff.

**Rationale and Summary**
Resident had an area of altered skin integrity for which they received treatment for. A weekly skin assessment on the resident's Treatment Administration Record (TAR) was initiated.

The order on the TAR was signed on the scheduled weekly skin assessment for a specified date. However, the weekly skin assessment was not completed for this date.

A Registered Practical Nurse (RPN), who was the Home's Wound Care Lead, clarified that the registered staff is responsible for completing the weekly skin assessment for residents. Furthermore, the weekly skin assessment is completed and the order is signed on the TAR until healed. An RN confirmed that the weekly skin assessment was not completed in the identified period.

Failure to complete the weekly skin assessment for the resident can increase the risk for the staff's inability to assess the progress of resident's altered skin integrity while on treatment and implement further interventions.

**Sources**: Resident's progress notes and treatment administration record; Interviews with staff; Home's policy titled "Wound Care Treatment". [000710]

## WRITTEN NOTIFICATION: Dealing with Complaints

**NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.

The licensee has failed to ensure that when a complaint was received regarding resident's care, a response was provided within 10 business days of the receipt of the complaint.

**Rationale and Summary**

A CIS report was submitted to the MLTC regarding care concerns related to a resident. The complaint was emailed to a staff in the home weeks prior. A response to the complainant was provided weeks after the receipt of the complaint.

The home's complaint policy directed the administrator to respond in writing to all written complaints within 10 business days of the receipt.

The Administrator acknowledged that a response was not provided to the complainant within the required timeline. They noted that the complaint was not immediately forwarded to them by the staff who received the email.

**Sources**: CIS report, Complaints Policy; interview with the Administrator. [741670]