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
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: January 15, 2024	
Inspection Number: 2023-1086-0005	
Inspection Type: Complaint Critical Incident	
Licensee: Chartwell Master Care LP	
Long Term Care Home and City: Chartwell Gibson Long Term Care Residence, North York	
Lead Inspector Rajwinder Sehgal (741673)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 3, 4, 8, 9, 10, 2024

The following intakes was inspected in the Critical Incident System (CIS) Inspection:

- Intake: #00094755 – [CI:2556-000027-23] related to falls prevention and management.

The following intake was inspected in the Complaint Inspection:

- Intake: #00101376 related to a resident's care.

The following intake was completed in the CIS Inspection:

- Intake: #00102625 – [CI:2556-000034-23] related to resident's fall.

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: MAINTENANCE SERVICES

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 96 (2) (b)

Maintenance services

s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

The licensee has failed to ensure that a resident's falls intervention device was kept in good repair.

Rationale and Summary

A resident had a fall and was found sitting on the floor. Upon assessment, it was noted that the resident's had a change in health condition, and they were experiencing pain in their specified body part. The resident was transferred to the hospital for further assessment.

The resident's care plan indicated that they use a specific device as part of their fall

prevention intervention strategy. During an observation, the resident was noted having a specific device in place, however device was not in a working order.

The Registered Nurse (RN) acknowledged that the device was not in a working order. The Director of Care (DOC) stated staff were responsible to ensure that the resident's device was in place and in working order.

Failure to ensure the resident's fall prevention device was in good repair resulted in a delay in staff responding to the resident's fall.

Sources: Resident's clinical records, Critical Incident System (CIS) report, interviews, RN and DOC.

(741673)

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2);

The licensee has failed to ensure that symptoms indicating the presence of infection

for a resident were monitored on every shift, in accordance with any standard or protocol issued by the Director.

The additional requirement under 3.1 (b) of the Standard was to ensure that surveillance was performed on every shift to identify cases of healthcare acquired infections (HAIs).

Rationale and Summary
The resident was diagnosed with an infection.

The home policy titled "Daily Infection Surveillance" last revised in March 2023 directed on every shift, registered staff to observe and assess residents for signs and symptoms during the course of the infection related to the resident status and actions taken, and document in the progress notes.

The resident's progress notes indicated that staff failed to monitor and record signs and symptoms of infection when the resident was being treated for the infection.

The RN verified that when a resident has symptoms of an infection, staff are to monitor the resident, and document the symptoms in a progress note on every shift. Infection Prevention and Control (IPAC) Lead reviewed the resident's progress notes and acknowledged staff had not monitored and documented on each shift when the resident had an infection.

Failure to monitor the resident's infection placed them at risk for inadequate treatment and delayed recovery.

Sources: Resident's progress notes and care plan, home's policy Daily Infection Surveillance LTC-CA-WQ-205-03-02 last revised March 2023, interviews with RN,

IPAC Lead and DOC.

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