

# 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: October 7,2024

Inspection Number: 2024-1097-0002

Inspection Type:

Critical Incident

Licensee: Chartwell Master Care LP

**Long Term Care Home and City:** Chartwell White Eagle Long Term Care Residence, Toronto

# **INSPECTION SUMMARY**

The inspection occurred onsite on the following date(s): September 23-25, 2024

The following Critical Incident (CI) intake was inspected:

• Intake: #00116699/ (CI) # 2583-000002-24 - related to an outbreak.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control

# **INSPECTION RESULTS**

# WRITTEN NOTIFICATION: CMOH and MOH

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

Non-compliance with: O. Reg. 246/22, s. 272

CMOH and MOH



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s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee failed to ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act were followed in the home.

In accordance with the Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective April 2024, section D. Contact Management, directs the Infection Prevention and Control (IPAC) Lead/ Designate to conduct weekly IPAC audits for the duration of the outbreak.

#### **Rationale and Summary:**

A Critical Incident (CI) Report was submitted to the Director and indicated a COVID-19 outbreak at the Long-Term Care Home (LTCH) from May 21 to June 5, 2024.

Upon reviewing the home's IPAC Self-Assessment audits during the outbreak, it was noted that they were completed on May 21, 2024, and then again on June 4, 2024. The IPAC Self-Assessment audit was not completed on May 28, 2024, during the home's COVID-19 outbreak.

The IPAC Lead acknowledged that the IPAC Self-Assessment audit was not completed on May 28, 2024.

Failure to complete weekly IPAC Self-Assessment audits may result in missed



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opportunities to identify gaps in infection control practices

**Sources:** CI #2583-000002-24, Weekly IPAC Self-Assessment Audits; interview with IPAC Lead.