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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: July 25, 2023	
Inspection Number: 2023-1075-0004	
Inspection Type: Critical Incident System	
Licensee: Chartwell Master Care LP	
Long Term Care Home and City: Chartwell Elmira Long Term Care Residence, Elmira	
Lead Inspector Kaitlyn Puklicz (000685)	**Inspector Digital Signature** Kaitlyn Joan Puklicz Digitally signed by Kaitlyn Joan Puklicz Date: 2023.07.25 14:55:10 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 20-21, 2023

The following intake(s) were inspected:

- Intake: #00086126 - Resident fall resulting in transfer to hospital and change of resident status.

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

Infection Prevention and Control
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. 6 (7)

Non-compliance with FLTCA, s. 6 (7) related to plan of care.

The licensee has failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified in the plan related to fall mats.

Rationale & Summary:

A resident's care plan stated there should be fall mats bilaterally in place as a fall intervention.

During observations, the resident had only one fall mat in place.

A staff member said that the resident should have both fall mats in place.

It was later observed that two fall mats were in place in the resident's room.

Sources:
Clinical record review for the resident, observations, interview with a staff member.

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Date Remedy Implemented: July 21, 2023

WRITTEN NOTIFICATION: Binding on licensees

NC #002 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 where the Act required the Licensee of a long-term care home to carry out every Minister's Directive that applies to the long-term care home, the Minister's Directive was complied with.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, prior to June 26, 2023, the Licensee was required to ensure that the Long-Term Care Home (LTCH) completed Infection Prevention and Control (IPAC) audits every two weeks when not in outbreak and weekly when in an

outbreak.

The licensee has failed to ensure that IPAC self-audits were completed every two weeks when the home was not in an outbreak.

Rationale and Summary:

A review of the IPAC self-audits that were provided by the IPAC Lead indicated the home did not complete the IPAC self-audits every two weeks as required by the Minister's Directive.

The IPAC Lead, said that the home did not complete the IPAC self-audits as required for the month of May 2023.

Failing to complete IPAC self-audits as required put the home at risk of failing to ensure measures are taken to prepare for and respond to a COVID-19 outbreak.

Sources:

Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, COVID-19 guidance document for long-term care homes in Ontario, updated March 31, 2023, IPAC self-audits provided by the home, and interviews with IPAC Lead.

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