Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 13, 2019	2019_598570_0026	014760-19, 019307-19	Critical Incident System

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

Long-Term Care Home/Foyer de soins de longue durée

Chartwell Bon Air Long Term Care Residence
131 Laidlaw Street South Cannington ON L0E 1E0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SAMI JAROUR (570), MOSES NEELAM (762)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 6, 7, 8, 12 and 13, 2019

The following intakes were inspected:
Log #014760-19, related to alleged staff to resident abuse.
Log #019307-19, related to a fall of a resident resulting in an injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Restorative Aide, and residents.

During the course of this inspection, the Inspector (s), toured specific resident rooms and common residents' areas, observed residents to residents interactions and staff to residents interactions, reviewed clinical records and relevant policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
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). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001 was assessed and the plan of care reviewed and revised related to falls because the care set out in the plan had not been effective, that different approaches were considered in the revision of the plan of care.

On an identified date, Critical Incident Report (CIR) was submitted to the Director. The CIR indicated resident #001 had been taken to the hospital as a result of a fall.

Resident #001's records were reviewed by Inspector #762 in Point Click Care (PCC). It was determined the resident was at risk for falls based on the "Scott Fall Risk Assessment" tool.

A review of the plans of care of identified dates by Inspector #762, indicated identified interventions for falls.

A review of the "Post Fall Assessment and Analysis" assessment of specified date by Inspector #762, indicated a recommendation of a specified intervention for falls. This intervention was not implemented until after resident #001 had a fall with an injury on an identified date.

The progress notes and assessments reviewed by Inspector #762 indicated resident #001 had fallen on identified dates. A review of the plan of care by Inspector #762 indicated no revision in the plan of care after each fall. The first revision for the plan of care under falls was made on an identified date, after the resident sustained an injury due to a fall.

Interviews with Inspector #762, Director of Care (DOC), Registered Practical Nurse (RPN) #104, Registered Nurse (RN) #106, and Restorative Aide #108 indicated the falls interventions aspect of the plan of care was not revised for a specified period. Resident #001 had a number of falls during this period.

The licensee failed to ensure that the plan of care was revised when the care set out in the plan has not been effective and that different approaches were considered in the revision of the plan of care for resident #001. Resident #001 had fallen on identified dates and the plan of care was not revised until after the resident sustained an injury due to a fall. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes 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 when a resident is reassessed and the plan of care reviewed and revised because care set out in the plan has not been effective, different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

Issued on this 16th day of December, 2019

[redacted]

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.