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_0025	015111-19	Complaint

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 Complaint inspection.

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

Complaint Log #015111-19, related to unsafe transfer and positioning of residents.

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), 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:
Personal Support Services
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning techniques when assisting resident #003.

A complaint was received through the Action Line on identified date, reporting an incident

of unsafe transferring involving resident #003 being transferred by a PSW staff without assistance of a second staff.

A review of the survey documentation report for resident #003 of an identified month, indicated PSW #101 transferred resident #003 using a lift on an identified date. The documentation indicated, the resident was totally dependent and was transferred by one staff.

A review of the plan of care for resident #003, indicated the resident required the use of a lifting device for safe transfer and assistance by two staff.

During separate interviews on an identified date, PSWs # 102, #103 and RPN #104 indicated to Inspector #570 that they were aware of the incident on an identified date, when PSW #101 assisted resident #003 using a lifting device without the assistance of a second staff. RPN #104 indicated that resident #003 did not have any injuries, however, the resident was at risk of being injured.

During an interview, the Director of Care (DOC), indicated to Inspector #570 that the expectation at the home that two staff should by present when a a lifting device is used to assist residents. The DOC indicated that PSW #101 did not perform a safe transfer when they transferred resident #003 without the assistance of a second staff.

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when PSW #101 transferred resident #003 using a lifting device without the assistance of a second staff. [s. 36.]

2. The licensee has failed to ensure that staff use safe transferring and positioning techniques when assisting resident #004.

A complaint was received through the Action Line on an identified date, reporting an incident involving resident #004 being left unattended in a specified area while being hooked-up on a lifting device.

A review of the home's policy titled: Mechanical Lifts and Resident Transfers, Policy #LTC-CA-WQ-200-07-12 revised July 2019, directed: two staff are required at all times when a mechanical device is used to transfer and/or lift a resident. Residents are never to be left alone in a lift or in a sling that is attached to any type of lift.

During an interview, PSW #103 indicated to Inspector #570 that they were aware of the incident when resident #004 was left unattended during a specified activity of daily living (ADL) and that staff should stay within the area by the resident.

During an interview, RPN #104 indicated to Inspector #570 that resident #004 required extensive assistance using a lifting device for a specific ADL. RPN #104 indicated the resident was found hooked up to the lifting device during a specified ADL with no staff present putting the resident at risk of harm. RPN #104 indicated that resident was assessed and had no injuries.

During an interview, RN #107 indicated to Inspector #570 that on specified date, resident #004 was transferred by two PSW staff using a lifting device. RN #107 indicated they spoke to PSW #111 who indicated to the RN that they left the resident during a specified ADL under the expectation that the other PSW who assisted with the lift would have stayed with the resident.

During an interview, the Director of Care (DOC), indicated to Inspector #570 that it was not a safe practice to leave the resident unattended while hooked to a sling that was attached to a lift. The DOC indicated that one staff should have stayed with the resident.

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when resident #004 was left unattended while attached to a sling and a lift. [s. 36.]

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 that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week. O. Reg. 79/10, s. 213 (1).
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week. O. Reg. 79/10, s. 213 (1).
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week. O. Reg. 79/10, s. 213 (1).
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week. O. Reg. 79/10, s. 213 (1).
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the DONPC work regularly in that position on site for at least the following amount of time per week:

4. In a home with 40 to 64 licensed beds, at least 24 hours.

In this report, the Director of Nursing and Personal Care (DONPC) is also referred to as the Director of Care (DOC).

Chartwell Bon Air Long-Term Care Residence is a 55 bed long-term care home.

During staff interviews throughout this inspection regarding incidents of unsafe transfers, it was revealed that the home did not have a DOC for two months and that in case of any nursing care concerns staff would bring their concerns to the charge nurse.

During an interview, the Director of Care (DOC), indicated to Inspector #570 that from a specified date, they continued at the LTC home as a DOC and RAI coordinator on a temporary basis covering both roles three days a week. The DOC acknowledged that they were not present for 24 hours a week as a DOC at the home and that their DOC hours were approximately twelve hours a week.

During an interview, the Administrator acknowledged that the home did not have DOC coverage at the home for a minimum of 24 hours a week since an identified date.

The licensee failed to ensure there was a DOC working on site for at least 24 hours per week from an identified date up to the last date of this inspection. [s. 213. (1)]

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 the Director of Care is available on site for at least 24 hours per week, to be implemented voluntarily.

Issued on this 16th day of December, 2019

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

Original report signed by the inspector.