Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection 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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 10, 2017	2017_646618_0019	021981-17	Resident Quality Inspection

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 Pine Grove Long Term Care Residence
8403 Islington Avenue North Woodbridge ON L4L 1X3

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

CECILIA FULTON (618), NICOLE RANGER (189), SUSAN SEMEREDY (501)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): September 18, 19, 20, 21, 22, 25, 26, 27, 28 and 29, 2017.

During the course of this inspection the following Critical Incident Intake Logs were inspected:
Intake Log #009502-17, related to an allegation of abuse and Log # 009673-17, related to improper transferring.

The following Complaint Intake Log(s) were inspected: #0012075-17, 009471-17, 014097-17, 004697-17,006869-17, related to Prevention of Abuse and Log #010132-16, related to Resident's Rights.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Dietitian (RD), Environmental Services Manager (ESM), Housekeepers (HSK), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Programs Manager, Activity Staff, Residents and Resident's family members.

During the course of the inspection, the inspectors conducted observations of residents and home areas, staff and resident interactions, provision of care, medication administration, infection control prevention and practice, reviewed clinical health records, minutes of Residents' Council and Family Council meetings, and relevant policy and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **4 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	Legendé 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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

This inspection was initiated to inspect items identified in Critical Incident Report (CIR) of May 2017, related to equipment not maintained in a good state of repair resulting in resident injury.

In May 2017, resident #007 required to be transferred from wheelchair to bed. Interview with PSW #108, while assisting with this transfer, resident #007's incurred an injury to an identified body part. PSW #108 reported that upon closer observation of the bed, there was a missing black plastic cap that should have been covering a round edge of the side rail handle, thus leaving a raw, steel end of the side rail handle exposed.

Interview with Director of Care (DOC) revealed that in May 2017, PSW #109, conducted an audit of the resident's bed on all floors and identified the beds that had missing black plastic caps from the bed frame. The DOC reported that she informed the Environmental Service Manager (ESM) of the missing caps that needed to be replaced

During the course of this inspection, the inspector conducted random observations of resident's beds. These observations revealed 6 resident beds on the first, second and third floors that were missing some or all of these pieces leaving an exposed steel end of the bed handle frame.

Interview with the Environmental Services Manager (ESM) revealed that through the May 2017, bed audit, 125 of these caps had been identified as missing, however it was not until a date in September 2017, that the ESM had ordered and received 20 black plastic caps (assist rail plugs), and did not order the additional 100 required plastic caps until until another date in September 2017 when this inspection identified the deficiency.

Interviews and observations with the DOC, RAI coordinator and ESM confirmed the missing black plastic caps on the 6 identified resident beds on the 3rd floor. The home had allowed the residents side rails to be in disrepair for four months, knowing the potential safety risk it posed.

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 the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #2: 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 used safe transferring techniques when assisting residents.

During an Inspector observation of resident #002's room the Inspector observed staff #119 in the process of transferring resident #022. Resident #022 was observed in the process of being mechanically transferred. PSW #119 was the only staff present.

When the inspector approached the room for this observation the door to the room had been closed, and no other staff were in the immediate area.

When staff #119 saw the inspector he/she stated that his/her partner, identified as PSW #120, had been helping but just left because they heard another resident, identified as resident #011, calling for help.

The Inspector left the room and spoke with registered staff #121 and told him/her what had been observed. Staff # 121 entered the resident's room.

When PSW #119 exited the room, the Inspector entered the room and observed resident #022 in his/her bed.

PSW #119 went and found PSW #120 who was witnessed exiting another resident's room, not the one he/she had gone to attend to.

Interview with PSW #120 revealed that he/she had been assisting PSW #119 with the transfer, but left the room when he/she heard resident #011 calling from down the hallway. PSW #120 revealed that he/she did not consider resident #011 was in danger or that it was an emergency situation and stated that resident #011 may have dropped something or wanted a drink.

Interviews with PSW's #119 and #120 revealed that they were both aware of the requirement that two staff be present for the entirety of a transfer and they both agreed that they had not followed the proper technique.

Interview with the DOC revealed that the staff had not used safe transferring techniques. [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 techniques when assisting residents, to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the residents.

During stage one of the Resident Quality Inspection (RQI), resident #003 triggered for Potential Side Rail Restraint through inspector initial observation.

Record review of resident #003 written plan of care did not include the use of side rails or the use of Personal Assistance Service Device (PASD) for the resident. Record review of the Bed System Assessment dated November 2016, indicated that the SDM did not want the use of any bed rails, and that the resident does not require side rails as the resident is able to safely enter and exit the bed. Review of the Consent for use of Personal Assistance Service Device (PASD) dated November 2016, the resident's SDM did not consent to the use of the bedrails as a PASD and declined the use of the PASD.

During this inspection the inspector observed two quarter rails in the up position at the head of the bed. The inspector also observed a picture singage titled " PASD Authorization Card" which stated that the resident had been assessed and approved for the bed rail PASD, on November 2016.

Interview with PSW #103 revealed that resident #003 uses the bed rails in to assist with bed mobility. Interview with the DOC revealed that the staff have reported to him/her that the resident uses the bed rails to assist with bed mobility. The DOC also reported that during the initial bed system assessment, the family did not approve for the use of the PASD.

Interview with the DOC confirmed that the written plan of care for resident #003 did not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 7. Nothing in this Act authorizes a licensee to assess a resident's requirements without the resident's consent or to provide care or services to a resident without the resident's consent. 2007, c. 8, s. 7.

Findings/Faits saillants :

1. The licensee has failed to ensure that nothing in this Act authorizes a licensee to assess a resident's requirements without the resident's consent or to provide care or services to a resident without the resident's consent.

During stage one of the Resident Quality Inspection (RQI), resident #003 triggered for Potential Side Rail Restraint through inspector initial observation.

Record review of resident #003 written plan of care did not include the use of side rails or the use of Personal Assistance Service Device (PASD) for the resident. Record review of the Bed System Assessment dated November 2016, indicated that the SDM did not want the use of any bedrails, and that the resident does not require side rails. Review of the Consent for use of Personal Assistance Service Device (PASD) dated November 2016, the resident's SDM did not consent to the use of the bedrails as a PASD and declined the use of the PASD.

During this inspection the inspector observed two quarter rails in the up position at the head of the bed. The inspector also observed a picture singage titled " PASD Authorization Card" which stated that the resident had been assessed and approved for the bed rail PASD, in November 2016.

Interview with PSW #103 revealed that resident #003 does use the bed rails in order to assist with bed mobility. Interview with the DOC revealed that the staff have reported that the resident uses the bed rails to assist with bed mobility. The DOC also reported that during the initial bed system assessment, the family did not approve for the use of the PASD and also reported that a meeting will be held with the family informing the resident uses the bed rails to assist with bed mobility, and to review the consent for the use of the PASD. [s. 7.]

Issued on this 30th day of October, 2017

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

Original report signed by the inspector.