Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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 9, 2020	2020_751649_0024	007861-20, 011287-20, 020637-20	Critical Incident System

Licensee/Titulaire de permis

Chartwell Master Care LP
7070 Derrycrest Drive Mississauga ON L5W 0G5

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

JULIEANN HING (649)

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 9, 19, and off-site on November 13, 14, 16, 18, and 30, 2020.

The following intakes were completed during this Critical Incident System (CIS) Inspection:
Log #007861-20/ CIS #2808-000003-20 related to plan of care.
Log #011287-20/ CIS #2808-000009-20 related to falls prevention and management.
Log #020637-20/ CIS #2808-000011-20 related to an outbreak in the home.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Physician, Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

During the course of the inspection the inspector reviewed residents' health records, investigation notes, staffing schedules, conducted observations related to the home's care processes, staff to resident interactions, and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in resident's plan of care related to the use of a safety device was provided to the resident.

A resident's care plan indicated the use of a safety device as a fall prevention. On November 9, 2020, the inspector observed a PSW transferred a resident from a regular chair in their room to their mobility device, leaving the safety device on the vacated chair. Approximately 20 minutes later the resident had self transferred themselves from the mobility device to their bed without staff being aware, and the safety device was left on the vacated chair. There was an increased risk of resident #002 falling while self transferring themselves without staff being aware, since the safety device was left by a PSW on the vacated chair in the residents' room.

Sources: CIS report, resident's care plan, inspector's observations, and interview with the DOC, and other staff. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to a resident two days in April 2020, when they were assessed as having pain.

According to a resident's clinical records there was documentation of pain assessments completed two days in April 2020, indicating that the resident had pain. No pain medication was administered to the resident on these two days, even though there was an existing as needed (PRN) order for Tylenol. The registered nurse acknowledged that no pain medication was administered to the resident on these two days, when they were assessed as having pain. Failure of staff to administer pain medication to the resident on these two days, led to the resident's pain not being properly managed by the home.

Sources: CIS report, resident's e-MAR including PRN orders, medical directives, progress notes, interview with DOC, and other staff. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 15th day of December, 2020

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

Original report signed by the inspector.