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
Jul 26, 2021	2021_890758_0014	000609-21, 001467-21	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

DANIELA LUPU (758), JANET GROUX (606)

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): June 11, June 14-18, and June 21-25, 2021.

The following intakes were completed during this Critical Incident (CI) inspection:

Log #000609-21, related to falls prevention and management; and

Log #001467-21, related to an allegation of neglect.

PLEASE NOTE: Written Notification (WN) and Voluntary Plans of Correction (VPC) related to O. Reg.79/10, s. 30 (2), were identified in this inspection and have been issued in inspection #2021_890758_0013, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC)/ Interim Infection Prevention and Control (IPAC) Lead, IPAC Lead, Environmental Services Manager (ESM), Registered Dietician (RD), Physiotherapist (PT), Public Health representatives, Physician, Registered Practical Nurses (RPN), Registered Nurses (RN), Personal Support Workers (PSW), receptionist, housekeeping staff, residents and their Substitute Decision Makers (SDM).

The inspector(s) observed staff to resident interactions, infection prevention and control practices and safety conditions of the home. They also reviewed clinical records, the home's policies and procedures, and documents pertinent to the inspection.

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

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

1 WN(s)
0 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. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report submitted to the Director, related to an allegation of neglect of a resident, included the names of staff members who were present during the incident.

A Critical incident (CI) reported an allegation that a resident was neglected by staff. The CI report was incomplete and did not contain the names of staff involved in the incident.

Director of Care (DOC) acknowledged this.

Sources: critical incident report, and an interview with the DOC. [s. 104. (1) 2.]

Issued on this 27th day of July, 2021

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

Original report signed by the inspector.