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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Amended Public Copy/Copie modifiée du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 30, 2021	2021_890758_0013 (A1)	022203-20, 000515-21, 007034-21, 007653-21	Complaint

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

Amended by DANIELA LUPU (758) - (A1)

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

The following intakes were completed during this complaint inspection:

Log #022203-20, regarding concerns related to a resident's elopement;

Log #000515-21, regarding concerns related to COVID-19 protocols and falls prevention and management.

Log #007034-21, and Log #007653-21, regarding concerns related to falls prevention, pain management, nutrition and hydration and provision of care.

PLEASE NOTE: Written Notification (WN) and Voluntary Plan of Correction (VPC) related to O. Reg.79/10, s. 30 (2), identified in a concurrent inspection #2021_890758_0014, Log #000609-21, were issued in this report.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC)/ Interim 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:

Critical Incident Response
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Pain
Personal Support Services
Reporting and Complaints
Safe and Secure Home
Training and Orientation

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

- **9 WN(s)**
- **6 VPC(s)**
- **1 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for a resident.

On an identified date, a resident came by the service elevator to the main lobby area, refused to be screened for COVID-19 and exited the home through the main entrance door. The screening staff could not verify the identity of the resident and did not notify the home about the incident.

The home was not aware of the resident's elopement until half an hour later when

the resident's family notified them that the resident had left the home. The resident was located approximately two hours and a half later by the Police authorities.

The resident's plan of care directed staff to complete safety checks at specified time intervals and document the checks in Point of Care (POC). The POC documentation on the date of the resident's elopement, showed that although the resident was not present in the home, Personal Support Worker (PSW) #137 continued to document that safety checks were completed for other two hours and that the resident received their nourishment.

Director of Care (DOC) said that screener should have informed the home immediately if they were not able to verify the identity of any individual who refused to be screened before leaving the home. They also said that staff should have been aware of the resident's whereabouts when they completed the safety checks as indicated in the resident's plan of care.

Observations on an identified date, showed that unlike other elevators in the home, the service elevator used by the resident allowed direct access to the main lobby area without requiring a door access code. The main door entrance which was common to the retirement and the long-term care residents did not require an access code to exit the home.

The Administrator and DOC said that a safety rounds process was not implemented in the home and acknowledged the potential risk associated with not having an access code to exit the home through the main door entrance.

Failing to ensure that safety and security procedures were developed and implemented resulted in actual risk of harm of the resident.

Sources: observations of the main entrance door area, critical incident report, resident's progress notes, care plan, POC documentation, and interviews with the Administrator, DOC and other staff. [s. 5.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: 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 when interventions to manage a resident's falls had not been effective, different approaches were considered in the revision of their plan of care.

A resident was at risk for falls and had multiple falls in the last three months. Their Post fall Assessment and Analysis identified the resident's root cause of their falls, but no new approaches were considered in their plan of care to address the resident's risk of falls.

A Personal Support Worker (PSW) and the home's Physiotherapist (PT) said that after a resident's fall, a post fall huddle was completed to discuss interventions to manage the resident's further risk of falls.

Failing to identify new approaches to manage the resident's risk of falls could have put the resident at further risk of falls.

Sources: resident's post fall assessment and analysis, fall risk assessment, care plan and interviews with staff. [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 that 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.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1.2) The heat related illness prevention and management plan for the home shall be evaluated and updated, at a minimum, annually in accordance with evidence-based practices. O. Reg. 79/10, s. 20 (1.2).

s. 20. (1.3) The heat related illness prevention and management plan for the home shall be implemented by the licensee every year during the period from May 15 to September 15 and it shall also be implemented,
(a) any day on which the outside temperature forecasted by Environment and Climate Change Canada for the area in which the home is located is 26 degrees Celsius or above at any point during the day; and O. Reg. 79/10, s. 20 (1.3).
(b) anytime the temperature in an area in the home measured by the licensee in accordance with subsections 21 (2) and (3) reaches 26 degrees Celsius or above, for the remainder of the day and the following day. O. Reg. 79/10, s. 20 (1.3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's heat related illness prevention and management plan was updated, at a minimum annually, in accordance with the evidence-based practices.

On April 1, 2021, a memorandum was shared by the Ministry of Long-Term Care (MLTC) with all long-term care homes and stakeholders regarding the enhanced cooling requirements. Effective May 15, 2021, the MLTC made amendments to cooling requirements in Ontario Regulation 79/10, under the Long-Term Care Homes Act (LTCHA), 2007, to enhance the safety and comfort of long-term care residents. The licensees were required to evaluate and update their heat related illness prevention and management plan, in accordance with evidence-based practices.

A review of the home's policy related to extreme heat and cold weather precautions, showed that the policy was not updated in accordance with the evidence-based practices and did not include the enhanced cooling requirements effective May 15, 2021.

The home's Environmental Service Manager (ESM) acknowledged that the home's policy was not updated to include the required amendments.

Sources: the home's Extreme Heat and Cold Weather Precautions policy, Ministry of Long-Term Care memorandum (April 1, 2021) and an interview with the ESM. [s. 20. (1.2)]

2. The licensee has failed to ensure that the home's heat related illness prevention and management plan was implemented in two resident home areas anytime when the temperature in an area of the home reached 26 degrees Celsius for the remainder of the day and the following day.

A review of the home's indoor air temperature and humidex monitoring records, showed that on multiple dates in May 2021, the temperatures recorded in the two designated cooling areas in two resident home areas were above 26 degrees Celsius in several occasions.

There was no documentation that the home's heat related illness prevention protocol was initiated when the temperatures were above 26 degrees Celsius for the remainder of the day and the following day on the identified dates.

The home's ESM verified that staff did not initiate the home's heat related illness prevention as required.

Sources: the home's indoor air temperature and humidex monitoring records, and an interview with the ESM. [s. 20. (1.3) (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 that the heat related illness prevention and management plan for the home is updated at a minimum annually, in accordance with the evidence-based practices; and is implemented anytime the temperature in an area in the home measured by the licensee in accordance with subsections 21 (2) and (3) reaches 26 degrees Celsius or above, for the remainder of the day and the following day, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature in the home was maintained at a minimum of 22 degrees Celsius in two resident home areas.

On identified date and times, the temperature was below 22 degrees Celsius in three designated cooling areas in two different resident home areas.

A review of the home's indoor air temperature and humidex monitoring records from May to June 20, 2021, revealed that on five occasions in May 2021, and on seven occasions in June 2021, the temperatures recorded were below 22 degrees in the designated cooling areas in two resident home areas. On an identified date in June 2021, the temperature in a resident's bedroom was below 22 degrees Celsius. There was no records that action was taken in relation to the

temperatures below 22 degrees Celsius.

The home's ESM said measures should have been implemented when the temperatures were below 22 degrees as per home's protocol.

Sources: observations, the home's air temperature and humidex monitoring records, and an interview with the ESM. [s. 21.]

2. The licensee has failed to ensure that the temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home.

The home's air temperature and humidex monitoring records from May 15 to June 20, 2021, revealed that until June 18, 2021, temperatures were not measured and documented in two resident bedrooms in different parts of the home.

The home's ESM said the home did not measure and record temperatures in at least two residents bedrooms until June 18, 2021, as required.

Failing to ensure that temperatures were measured and recorded in at least two resident bedrooms in different parts of the home, increased the risk associated with temperatures changes outside of the normal range.

Sources: the home's air temperature and humidex monitoring records, and an interview with the ESM. [s. 21. (2) 1.]

3. The licensee has failed to ensure that temperatures were measured and documented at least once every morning, every afternoon and every evening or night throughout the home.

The home's indoor air temperature and humidex monitoring records from May 15 to June 13, 2021, revealed that throughout the home, temperatures in the designated cooling areas were measured only once daily. Further review of the indoor air temperature logs from June 14 to June 20, 2021, showed that the air temperatures were not measured three times daily.

The home's ESM said that the home did not measure and record air temperatures throughout the home twice daily until June 14, 2021, and three times daily until June 21, 2021.

Failing to ensure that the temperatures were measured and recorded three times daily as required increased the risk of harm to residents related to risks associated with temperatures outside of the normal range.

Sources: the home's air temperature and humidex monitoring records, and an interview with the ESM. [s. 21. (3)]

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 ensure that the temperature is maintained at the minimum 22 degrees Celsius and measured and documented in writing, at a minimum in at least two resident bedrooms in different parts of the home, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that three residents' safety checks were documented as specified in the residents' falls management plan of care.

A. Resident #002 was identified at risk for falls. The resident's plan of care

directed staff to complete safety checks at specified time intervals during each shift and to document them in the resident's Point of Care (POC). On an identified date, the resident had an unwitnessed fall.

Resident #002's POC documentation showed that on the date of their fall, the safety checks were not documented for seven hours. Additionally, during the five days prior to the resident's fall, 24 safety checks were missed and 88 entries were not documented as required in the resident's plan of care.

The DOC and a Registered Nurse (RN) said that safety checks should be completed as indicated in the resident's plan of care and documented as soon as possible after they were completed.

B. Resident #005 fell and sustained injuries. Their plan of care directed staff to complete safety checks to ensure the resident's fall prevention devices and equipment were in place and in good working condition.

Resident's POC documentation in the last seven months, showed 72 missed safety checks to indicate the interventions were completed on the resident. The DOC acknowledged this.

C. Resident #006 was at risk for falls. Their plan of care directed staff to completed safety checks to ensure the resident's fall prevention devices and equipment were in place and in good working condition.

Resident #006's POC documentation in the last six months, showed 32 missed entries between the days, evenings and night shifts to indicate staff completed the safety checks on the resident. The DOC acknowledged this.

Failing to ensure that residents #002, #005, and #006's safety checks related to falls prevention were documented as indicated in their plan of care, increased the risk that the effectiveness of these interventions could not be evaluated and could have resulted in harm to the residents.

Sources: residents #002, #005, and #006's care plans, POC documentation, resident #002's progress notes, and interviews with the DOC and other staff. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff member #121 received training related to the home's emergency procedures and infection prevention and control practices before the person began performing their responsibilities.

On an identified date, during a COVID-19 outbreak at the home, staff member #121 did not notify the home regarding an incident of a resident's elopement following their refusal to comply with the home's screening procedures.

Staff #121's training records revealed their training related to the home's emergency plans and IPAC practices were not completed prior to them starting performing their responsibilities.

The home's Administrator verified that there were no training records for staff #121 completed prior to performing their responsibilities.

Failing to ensure that the staff member #121 received the training on the home's IPAC and emergency procedures, increased the risk that appropriate measures were not implemented immediately and could have resulted in harm to the resident.

Sources: critical incident report, the home's employees training records, and an interview with the Administrator. [s. 76. (2)]

2. The licensee has failed to ensure that all staff received training related to the amendments of the O. Reg 79/10, regarding the enhanced cooling requirements.

On April 1, 2021, the MLTC shared a memorandum with all long-term care homes and stakeholders about the amendments to O. Reg. 79/10 under the Long-Term Care Homes Act, 2007, in relation to the enhanced cooling requirements effective on May 15, 2021.

A review of the home's employees training records showed no records of employees training related to the enhanced cooling requirements before May 15, 2021.

The home's ESM indicated staff training on new cooling requirements was started after June 11, 2021. They also indicated that all housekeeping staff and approximately 40 per cent of the nursing staff had received training on the enhanced cooling requirements by June 23, 2021.

Failing to ensure that all staff received training related to enhanced cooling requirements increased the risk that appropriate measures were not implemented to mitigate the risks associated with high temperatures and heat related illness.

Sources: Ministry of Long-Term Care memorandum (April 1, 2021), the home's employees training records and an interview with the ESM. [s. 76. (4)]

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 no person mentioned in subsection (1) performs their responsibilities before receiving training in emergency and evacuation procedures and infection prevention and control practices; and the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulation, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the home's Infection Prevention and Control (IPAC) program, in relation to appropriate usage of Personal Protective Equipment (PPE), staff and resident hand hygiene and cleaning and disinfecting of frequently touched contact surfaces using a low level disinfectant.

On March 17, 2020, the Premier of Ontario and Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act. On March 22 and 30, 2020, Directive #3 was issued on June 4, 2021, effective June 9, 2021, to all Long-Term Care Homes (LTC Homes) under the Long-Term Care Homes Act (LTCHA), 2007, under section 77.7 of the Health Protection and Promotion Act (HPPA) R.S.O. 1990, c H.7. by the Chief Medical Officer of Health (CMOH) of Ontario. The CMOH advised that residents of LTC Homes were at immediate and increased risk of COVID-19 and an urgent requirement was made for all LTC Homes to implement measures to protect all residents and staff.

The information gathered during the course of this inspection showed incorrect use of PPE, breaches in hand hygiene practices for staff and residents and incorrect cleaning of equipment.

A) On one occasion, PSW #106 was observed wearing their mask below their nose while serving the lunch meal in the dining room in one of the resident home areas. On a different occasion, PSW #138 was observed without eye protection while at the nursing station in another resident home area during the shift report.

The DOC/Interim IPAC lead stated that staff were to wear masks and eye protection at all times while in the resident home areas.

On two separate occasions, a staff member who had a medical exemption from wearing eye protection, was observed without an eye protection while being within two meters of the residents.

A Public Health representative from Regional Municipality of York said that staff should wear eye protection at all times when within two meters of a resident. They also said any staff member with a medical exemption from wearing eye protection should be reassigned from activities requiring to be within two meters of residents.

B) On two different occasions, before and after the lunch meal, multiple residents were offered for their hand hygiene products that did not contain at least 70 per cent alcohol as required.

The DOC/Interim IPAC Lead said that hand sanitizer containing at least 70 per cent alcohol should be used for the residents hand hygiene.

C) On one occasion, a PSW was observed not performing hand hygiene after disposing soiled dishes and before handing a resident clean paper napkins during a lunch meal service.

The DOC/Interim IPAC Lead said that staff should perform hand hygiene as indicated in the home's hand hygiene program.

D) On an identified date, on two separate occasions, a PSW was observed clean the meal tray carts without using a low level disinfectant.

The DOC/IPAC Lead said that wipes containing 0.5 per cent peroxide hydroxide should be used to clean hard surfaces, such as the meal trays carts.

Failing to ensure staff participated in the home's IPAC program increased the risk of transmission of viruses and bacteria to residents, staff and visitors throughout the home.

Sources: dining observations, the home's IPAC policy, Directive #3 (June 2021), PHO - Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings. 3rd Edition, April 2018, PHO – PIDAC “Best Practices for Hand Hygiene in All Health Care Settings", 4th Edition, April 2014, and interviews with DOC/Interim IPAC Lead, Administrator and other staff. [s. 229. (4)]

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 participate in the implementation of the home's Infection Prevention and Control (IPAC) program, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record of a verbal complaint that included the nature of the complaint, the date the complaint was received, the type of action taken to resolve the complaint, the final resolution, every date on which any response was provided to the complaint and a description of the response and any response made by the complainant was kept in the home.

A complaint was received by the MLTC alleging lack of response from the home regarding the home's safety and security procedures in relation to an incident of a resident's elopement.

The resident's family expressed concerns to the home related to the safety procedures in the home. A day after the incident, the resident's progress notes showed no evidence of details or the follow up regarding the incident.

There was no record of the resident's family member complaint at the time of the inspection.

The home's former Administrator said complaints not resolved within 24 hours should be logged in the home's complaint log work book.

The home's current Administrator could not locate the home's complaint log work book containing the complaint related to the resident's elopement.

Sources: the home's complaint log work book, interviews with the home's former and current Administrators and other staff. [s. 101. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written report related to resident's elopement included the long-term actions planned to correct the situation and prevent recurrence.

A Critical Incident (CI) was submitted to the Director, related to a resident's elopement from the home. The report did not include the long-term actions to correct the situation and prevent recurrence.

The home's Administrator said they could not locate any investigation records in relation to the incident.

Sources: critical incident report, resident's progress notes and interviews with former Administrator, former acting Administrator and current Administrator. [s. 107. (4) 4.]

Issued on this 30th day of July, 2021 (A1)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by DANIELA LUPU (758) - (A1)
Inspection No. / No de l'inspection :	2021_890758_0013 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	022203-20, 000515-21, 007034-21, 007653-21 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 30, 2021(A1)
Licensee / Titulaire de permis :	Chartwell Master Care LP 7070 Derrycrest Drive, Mississauga, ON, L5W-0G5
LTC Home / Foyer de SLD :	Chartwell Pine Grove Long Term Care Residence 8403 Islington Avenue North, Woodbridge, ON, L4L-1X3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Niloshini Sivanandan

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To Chartwell Master Care LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must be compliant with s. 5 of the LTCHA.

Specifically, the licensee must ensure that:

A) A safety rounds plan is developed and implemented in the home to monitor all residents' whereabouts. The plan should include the times for rounds, the person responsible, and steps taken when concerns are identified. A record of this plan should be kept in the home and be made accessible to staff.

B) A system for completing safety rounds of the home during the hours of 2300 hrs and 0700 hrs and whenever the main entrance door is not supervised. The plan should include the time for safety rounds, the person responsible, the areas to be checked and steps taken when concerns are identified. A record of this plan should be kept in the home and be made accessible to staff.

C) All staff receive training on the home's emergency procedures before starting their responsibilities.

D) Implement and complete weekly audits on PSW #137's Point of Care (POC) and hourly checks documentation to ensure that it is done accurately and timely according to the home's policy. The audits should be completed until no further concerns arise with the staff member's documentation.

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Grounds / Motifs :

1. The licensee has failed to ensure that the home was a safe and secure environment for a resident.

On an identified date, a resident came by the service elevator to the main lobby area, refused to be screened for COVID-19 and exited the home through the main entrance door. The screening staff could not verify the identity of the resident and did not notify the home about the incident.

The home was not aware of the resident's elopement until half an hour later when the resident's family notified them that the resident had left the home. The resident was located approximately two hours and a half later by the Police authorities.

The resident's plan of care directed staff to complete safety checks at specified time intervals and document the checks in Point of Care (POC). The POC documentation on the date of the resident's elopement, showed that although the resident was not present in the home, Personal Support Worker (PSW) #137 continued to document that safety checks were completed for other two hours and that the resident received their nourishment.

Director of Care (DOC) said that screener should have informed the home immediately if they were not able to verify the identity of any individual who refused to be screened before leaving the home. They also said that staff should have been aware of the resident's whereabouts when they completed the safety checks as indicated in the resident's plan of care.

Observations on an identified date, showed that unlike other elevators in the home, the service elevator used by the resident allowed direct access to the main lobby area without requiring a door access code. The main door entrance which was common to the retirement and the long-term care residents did not require an access code to exit the home.

The Administrator and DOC said that a safety rounds process was not implemented in the home and acknowledged the potential risk associated with not having an access code to exit the home through the main door entrance.

Failing to ensure that safety and security procedures were developed and

implemented resulted in actual risk of harm of the resident.

Sources: observations of the main entrance door area, critical incident report, resident's progress notes, care plan, POC documentation, and interviews with the Administrator, DOC and other staff.

An order was made by taking the following factors into account:

Severity: A resident was not monitored for safety and eloped from the home resulting in actual risk of harm to the resident.

Scope: This was an isolated case as no other incidents of elopement were identified during this inspection.

Compliance History: Three Written Notifications (WN), two Voluntary Plans of Correction (VPC) and one Compliance Order (CO) which has been complied with, were issued to the home related to different sections of the legislation in the last 36 months.

(758)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 12, 2021(A1)

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REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 30th day of July, 2021 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by DANIELA LUPU (758) - (A1)

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Service Area Office / Bureau régional de services : Toronto Service Area Office