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 sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 25, 2016	2016_243634_0006	010476-16, 008679-16	Critical Incident System

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 Parkhill Long Term Care Residence
250 TAIN STREET P.O. BOX 129 PARKHILL ON N0M 2K0

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

ADAM CANN (634)

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): May 5 and 6, 2016

The following Critical Incident inspections were conducted concurrently during this inspection:

Critical Incident System # 2632-000004-16 Log # 008679-16 related to Abuse and Neglect
Critical Incidnet System # 2632-000006-16 Log # 010476-16 related to Abuse and Neglect

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, Program Support Services Manager, three Personal Support Workers (PSW), one Registered Practical Nurse (RPN), one Registered Nurse (RN), and one Housekeeper.
The Inspector also reviewed the critical incident, resident clinical records, and policies and procedures related to this inspection.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are not neglected by the licensee or staff.

On a specified date, the home reported to the Director that care was not provided to a resident as per their plan of care.

The home's investigation into the incident confirmed that on a specified date, care was not provided to a resident as per their turning and positioning plan of care. The resident had altered skin integrity as a result.

Interview with a Personal Support Worker (PSW) confirmed that she was the assigned PSW for resident on the specified date. The PSW confirmed that the care was not provided as per the resident's care plan which resulted in altered skin integrity.

Record review of an email written from Registered Nurse (RN) to the Administrator/DOC confirmed that a PSW had reported an incident where care was not provided to a resident as per their plan of care. The RN confirmed that the result of the incident was altered skin integrity.

The licensee failed to protect the resident from neglect by the licensee or staff. [s. 19. (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 with ensuring residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

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. (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 the plan of care was provided to the resident as specified in the plan.

Record review of an email written from a Registered Nurse (RN) to the Administrator/DOC revealed that on a specified date care was not provided to a resident as per their plan of care. The email indicated that at the time, the resident had altered skin integrity as a result.

Review of the care plan interventions for bed mobility for the resident indicated "Turning and positioning routine for resident is every two hours when in bed".

Interview with a PSW confirmed that on a specified date care was not provided to a resident as per their plan of care related to turning and positioning.

Record review of the home's investigation notes when Assistant Director of Care (ADOC) spoke with the PSW indicated that on a specified date care was not provided to a resident as per their plan of care.

Interview with Administrator/Director of Care confirmed that the resident was not repositioned as per the plan of care.

Administrator/DOC acknowledged that it was an expectation that staff follow the resident's plan of care. [s. 6. (7)]

Issued on this 26th day of May, 2016

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

Original report signed by the inspector.