



**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**

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de
London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 30, 2016	2016_243634_0024	031065-16	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 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), INA REYNOLDS (524), SHERRI GROULX (519)

Inspection Summary/Résumé de l'inspection



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

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

This inspection was conducted on the following date(s): November 22, 23, 24, 25, and 28, 2016.

The following Critical Incident Systems Inspection was conducted concurrently during this inspection:

Critical Incident log # 031065-16, CIS # 2632-000007-16, related to a resident fall

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, the Assistant Director of Care, the Food Service/Environmental Manager, a corporate consultant, one Registered Nurse, two Registered Practical Nurses, five Personal Support Workers, a maintenance staff member, a member from Family Council, a member from Residents' Council.

The inspector (s) conducted a tour of the home, reviewed clinical records and plan of care for relevant residents, pertinent policies and procedures, Residents' and Family Council minutes and the staff schedule. Observations were also made of general maintenance, cleanliness, and condition of the home, infection prevention and control practices, provision of care, staff to resident interactions, medication administration, and required Ministry of Health and Long Term Care postings.

The following Inspection Protocols were used during this inspection:

**Contenance Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council**



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	
<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home



Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

- 1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,**
 - i. kept closed and locked,**
 - ii. equipped with a door access control system that is kept on at all times, and**
 - iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,**
 - A. is connected to the resident-staff communication and response system, or**
 - B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.**
- O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to, were kept closed and locked.

During the initial tour of the home, a door with a key pad leading to a housekeeping room was found to be open and unattended. This door had a keypad which required a pass code to unlock the door, when in fact it was able to be opened by the inspector. Cleaning chemicals were observed on the floor accessible to residents.

This was acknowledged by maintenance staff who said that this door should have self-closed and it did not. Upon interview with the Administrator, it was stated that a service company had been called for repairs and that this housekeeping door should be kept locked.

The licensee failed to ensure that a door on the Country home area, leading to a non-residential area, was kept closed and locked. [s. 9. (1) 1.]



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

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

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

Issued on this 30th day of November, 2016

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

Original report signed by the inspector.