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 prévue 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

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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
Mar 13, 2019	2019_644507_0007	009063-17, 014424-17, 025834-17, 028092-17, 000930-18, 009806-18, 021725-18	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 Gibson Long Term Care Residence
1925 Steeles Avenue East NORTH YORK ON M2H 2H3

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

STELLA NG (507)

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): March 4 - 8 , 11 - 12, 2019.

The following critical incident reports were inspected concurrently with this inspection:
#025834-17 (CIS #2556-000005-17), #009063-17 (CIS #2556-000018-17), #028092-17 (CIS #2556-000023-17) and #021725-18 (CIS #2556-000021-18) related to alleged staff to resident abuse,
#014424-17 (CIS #2566-000012-17) related to improper transfer, and
#000930-18 (CIS #2556-000002-18) and #009806-18 (CIS #2556-000014-18) related to outbreak management.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Services (DRS), Assistant Director of Nursing (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

The inspector conducted observations of staff and resident interactions, provision of care, record review of resident and home records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services
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	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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The Licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

On an identified date, an identified critical incident system (CIS) report was submitted to

the Ministry of Health and Long Term Care (MOHLTC) in regard to improper transfer techniques.

Review of the CIS indicated that when reviewing some video footage, the home noted staff #121 transferred residents #005 and #006 without the use of a mechanical lift or the assistance of another staff member.

Review of resident #005's written plan of care completed one day prior to the above mentioned transfer indicated the resident required a specific type of mechanical lift for positioning in bed, another type of mechanical lift and two person assistance for all transfers.

Review of resident #006's written plan of care completed approximately three weeks prior to the above mentioned transfer indicated that the resident required two person assistance for all transfers.

Review of the home's investigation notes indicated that during an interview, staff #121 told the home that on the identified date, staff #121 transferred resident #006 without the assistance of another staff member. During the same interview, staff #121 also stated that the next day staff #121 transferred resident #005 without the use of a mechanical lift or the assistance of another staff member. Both residents did not sustain any injury during the above mentioned transfers. It was confirmed by an interview with staff #109.

Resident #005 was no longer residing in the home.

Staff #121 was no longer working in the home, therefore an interview was not conducted.

On an identified date, at an identified time, the inspector observed staff #113 and #114 transfer resident #006 from bed to chair. The inspector observed both staff sit resident #006 on the edge of bed while standing on both sides of the resident. Staff #113 and #114 then placed one arm under resident #006's arm, and the other hand held the resident's pants at the waist. Then the staff transferred the resident onto the chair. During the transfer, the inspector did not observe resident #006 participate in the transfer.

Review of resident #006's written plan of care completed approximately 10 weeks prior indicated that the resident could participate and required two person assistance for all transfers.

In an interview, staff #113 stated that resident #006 was not able to participate in two people transfer at specific times of the day. Staff #113 further stated staff members have been transferring resident #006 without the resident's participation during the specific times for the past five months.

In interviews, staff #109 and #122 stated that when performing a two person assistance transfer of a resident, staff should engage the resident to participate. Staff #109 and #122 acknowledged staff #113 and #114 did not use proper transfer technique when transferred resident #006 on the above mentioned date. [s. 36.]

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 use safe transferring and positioning devices or techniques when assisting residents, 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the assessment of the resident so that their assessment are integrated and are consistent with and complement each other.

On an identified date, an identified CIS report was submitted to the MOHLTC in regard to improper transfer techniques.

On an identified date, at an identified time, the inspector observed staff #113 and #114 transfer resident #006 from bed to chair. The inspector observed both staff sit resident #006 on the edge of bed while standing on both sides of the resident. Staff #113 and #114 then placed one arm under resident #006's arm, and the other hand held the resident's pants at the waist. Then the staff transferred the resident onto the chair. During the transfer, the inspector did not observe resident #006 participate in the tranfer.

Review of resident #006's written plan of care completed approximately 10 weeks prior indicated that the resident could participate and required two person assistance for all transfers.

In an interview, staff #113 stated that resident #006 were not able to participate in two people transfer at specific times of the day. Staff #113 further stated staff members have been transferring resident #006 without the resident's participation during the specific times for the past five months. Staff #113 also stated that they have not informed the registered staff of the resident's changed status.

In an interview, staff #122 acknowledged staff should have informed registered staff of the resident's changed status, so that a referral can be made to the physiotherapist for a transfer assessment.

In an interview, staff #109 stated that staff should have informed the registered staff when resident #006 was not able to participate in a two person assistance transfer; so that an assessment can be completed. [s. 6. (4) (a)]

Issued on this 14th day of March, 2019

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

Original report signed by the inspector.