Ontario

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 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
Nov 25, 2019	2019_644507_0030	009967-19, 011134-19, 017894-19	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): November 14, 15, 18 and 19, 2019.

The following intakes were completed during this CIS inspection:
Log #009967-19, #011134-19 and #017894-19 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOC), Resident Assessment Instrument - Minimum Data Set (RAI-MDS) Coordinator, Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) 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:
Falls Prevention
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 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 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).

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 staff and others involved in the different aspects of care of resident #002 collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complement each other.

An identified Critical Incident System (CIS) report was submitted to the Director on an identified date, in regards to resident #002's fall which occurred the day prior. Resident #002 sustained an injury from the fall.

A) Review of the resident assessment instrument - minimum data set (RAI-MDS) completed approximately three months prior to the above mentioned fall, indicated the resident required an identified level of assistance (level A) with certain activity daily livings (ADLs). Review of the care plan completed one week later indicated the resident required a different level of assistance (level B) with same ADLs.

Review of resident #002's resident assessment protocol (RAP) completed on the same day as the RAI-MDS indicated falls RAP was triggered. Review of resident #002's care plan completed one week later did not include a focus for risk for falls and related interventions.

In an interview, staff member #101 stated the RAI-Coordinator is responsible for completing the RAI-MDS assessments for all new admissions, and assign registered staff to complete the care plans. The registered staff are responsible for completing the

assigned care plans based on the completed RAI-MDS assessments. When the care plans are signed off by the registered staff, the RAI-Coordinator locks the care plan. Staff member #101 further stated when they lock the care plan, they do not review the care plan to ensure the care plan reflects the RAI-MDS assessment.

In an interview, staff member #100 stated that on an identified date, resident #002 was provided care with level B assistance as per care plan at the time. During care, resident #002 fell.

In interviews, staff member #106 and #107 confirmed that there was lack of collaboration between the staff member who completed the RAI-MDS assessment and the registered staff who completed the care plan on the identified date for resident #002 in the identified areas of ADLs and falls prevention.

B) Review of the current care plan for resident #002 indicated the resident required level A assistance for the identified areas of ADLs.

During an interview conducted on an identified date, staff member #100 told the inspector that resident #002's care plan was revised from level B assistance to level A assistance since the fall occurred approximately six months ago. However, since the resident had improved, staff member #100 asked the family member whether the care level could be changed to level B, and the family member agreed. Staff member #100 further stated that they have been providing care to resident #002 with level B assistance since then. In addition, resident #002's improved condition and the conversation with the family member had not been reported to the registered staff.

In an interview, staff member #107 confirmed there was lack of collaboration in developing and implementing resident #002's current plan of care. [s. 6. (4) (b)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan.

An identified CIS report was submitted to the Director on an identified date, in regards to resident #002's fall which occurred approximately six months ago. Resident #002 sustained an injury from the fall.

On an identified date, at an approximate time, the inspector observed staff member #100 providing identified ADLs to resident #002 with level B assistance.

Review of resident #002's current care plan indicated the resident required level A assistance for the identified ADLs.

In an interview, staff member #107 confirmed the care set out in the plan of care, in particular the identified ADLs, was not provided to resident #002 by staff #100 as specified in the plan on the above mentioned identified date. [s. 6. (7)]

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:
1. the staff and others involved in the different aspects of care of resident #002 collaborate with each other, 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, and
2. the care set out in the plan of care is provided to resident #002 as specified in the plan, to be implemented voluntarily.

Issued on this 25th day of November, 2019

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

Original report signed by the inspector.