



**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**

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

**Division de la responsabilisation et de la
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Direction de l'amélioration de la
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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
Jul 24, 2015	2015_413500_0011	T-2276/2530-15	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

PINE GROVE LODGE
8403 Islington Avenue North Woodbridge ON L4L 1X3

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

NITAL SHETH (500)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 22 and 23, 2015.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aide, and the Resident.

**The following Inspection Protocols were used during this inspection:
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	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 use safe transferring and positioning devices or techniques when assisting residents.

A review of a critical incident report #2808-000004-15 revealed PSW #100 had used an improper equipment to transfer resident #001 on an identified day. The critical incident further revealed the resident experienced pain during the improper transfer.

A review of the resident's plan of care indicated the resident required total assistance for transfers by two staff via specified equipment.

A review of the home's policy #LTC-CA-WQ-200-07-16, entitled "Safe Transfer Program", revised November 2014 indicated staff to use information on the care plan and all employees are expected to comply with appropriate resident handling programs.

Interview with Resident Assessment Instrument (RAI) Coordinator #108 confirmed PSW #100 admitted attempting to transfer the resident using a wrong equipment without the assistance of a second staff member during the home's investigation.

Interview with Director of Care (DOC) #109 confirmed PSW#100 had put resident #001 at risk using an improper equipment to transfer the resident. [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.



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Issued on this 24th day of July, 2015

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

Original report signed by the inspector.