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 soins 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
Dec 8, 2016	2016_405189_0019	031812-16	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 White Eagle Long Term Care Residence
138 DOWLING AVENUE TORONTO ON M6K 3A6

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

NICOLE RANGER (189), VERON ASH (535)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 7, 8, 10, 14, 15, 16, 17, 2016.

The following intakes were inspected concurrently during this Resident Quality inspection (RQI): Critical Incident (CI) intakes related to responsive behaviours: #001217-15, 017116-15, 009293-15, 026579-16.

During the course of the inspection, the inspector(s) spoke with Administrator, Acting Director of Care (DOC) Assistant Director of Care (ADOC), Program and Support Service Manager, Food Service Manager, Maintenace Coordinator, Nurse Consultant, Registered Dietitian, Resident Council Vice- President registered staff, housekeeping aide, personal support workers, residents and family members.

During the course of the inspection, the inspectors conducted a tour of the unit, observed resident and staff interactions, reviewed clinical health records, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 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 O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented in accordance with manufacturer's specifications, using at a minimum a low level disinfectant in accordance with evidence-based practices and, if there are none, with prevailing practices, for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and contact surfaces.

On two identified dates in November 2016, the inspector observed that the shower stalls on three floors of the home had an overgrowth of black coloured substance present on the tiles and in the grout. During an interview with housekeeping staff #110 he/she stated that they noticed the presence of mold in the shower stalls since approximately July 2016. Interview with the Administrator and Housekeeping Manager #100 revealed that the shower rooms had low ventilation which causes a build up of moisture which fosters the growth of mold and mildew. During the interview, the Administrator acknowledged that they do not have a process in place to address this issue, however the team were currently implementing temporary measures to address the issue until permanent replacement of all shower stalls occurs in the near future.

On an identified date in November 2016, the inspector observed resident #001 sitting in an uncleaned wheelchair in the residents' lounge. The inspector also observed resident #002 using an uncleaned walker in his/her room. During interviews with PSW #109 and registered staff #112, the staff stated that residents' wheelchairs and walkers were to be cleaned on Tuesdays and Thursdays during the night shift, and that all staff were responsible for cleaning residents wheelchairs in case of accidental soiling during their shift. Record review confirmed that residents wheelchairs, walkers and geri-chairs were to be cleaned every Tuesday and Thursday however, the home does not have a log for PSW's to document after cleaning wheelchairs and walkers. During an interview, Assistant Director of Care (ADOC) #114, stated that the expectations were for PSW working the night shifts to clean residents wheelchairs and walkers as noted on the cleaning schedule, and that staff working all shifts were responsible for cleaning residents wheelchairs and walkers as required. [s. 87. (2) (b)]

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 procedures are developed and implemented for cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices: (ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and (iii) contact surfaces, 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of care set out in the plan of care is documented.

Record review of resident #020's progress notes revealed that on an identified date in August 2016, resident #020 exhibited responsive behaviour towards resident #022. The home's Dementia Observation System/Behavioural Observation Assessment tool was initiated on an identified date, and the home's expectation was for the PSW to document resident #020's behaviours every 30 minutes on day, evening and night shifts. Record review of resident #020's Dementia Observation system/Behavioural Observation Assessment during an identified time period in August 2016, revealed the resident's behaviours were not documented every thirty minutes on six identified dates.

Record review for resident #020's progress notes revealed that on an identified date in September 2016, resident #020 exhibited responsive behaviour towards resident #021. Record review of resident #020's Dementia Observation system/Behavioural Observation Assessment during an identified time period in September 2016, revealed the resident's behaviours were not documented every thirty minutes on five identified dates.

Record review for resident #020's progress notes revealed that on an identified date in October 2016, resident #020 pushed the main door and was found outside the home, staff brought the resident back into the home within a few minutes. Record review of resident #020's Dementia Observation system/Behavioural Observation Assessment during an identified time period in October 2016, revealed the resident's behaviours were not documented every thirty minutes on three identified dates.

Interviews with registered staff #116, PSW #115, and the ADOC confirmed that documentation was not completed to track the resident's behaviours on the above identified dates. [s. 6. (9) 1.]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which is based to the Director about abuse of a resident by anyone that resulted in harm or a risk of harm to the resident.

Review of resident #020's progress notes on an identified date, indicated that there was an altercation between resident #020 and resident #021. Progress notes revealed that resident #020 exhibited responsive behaviour towards resident #021.

Interview with PSW #115 who worked on the identified date, revealed that resident #021 stated that resident #020 had responsive behaviour towards him/her. Interview with the Administrator revealed that he/she followed up with resident #021 regarding the incident, and resident #021 reported that he/she wanted the police called about the incident. The police were contacted and came to investigate the incident. Interview with the Administrator confirmed that the altercation and abuse between these residents that resulted in harm was not reported to the Director. [s. 24. (1)]

Issued on this 9th day of December, 2016

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

Original report signed by the inspector.