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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 10, 2019	2019_654618_0022	000015-19	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 White Eagle Long Term Care Residence
138 Dowling Avenue TORONTO ON M6K 3A6

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

CECILIA FULTON (618)

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): June 4, 5, 6, 2019.

Intake Log #000015-19, CIS report #2583_000001_19 were inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, Registered Staff (RN) and Personal Support workers (PSW).

During the course of the inspection, the inspector observed residents and resident home areas, and conducted reviews of resident records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to resident #001.

This inspection was initiated to inspect a reported resident fall.

Record review identified the Minimum Data Set (MDS) assessment most relevant to the fall date, assessed resident #001as requiring extensive, two plus person assistance for toileting and transferring. Resident #001's plan of care at the time of the fall, identified resident #001's transfer interventions as requiring extensive assistance of one or two staff for all transfers, and specified that a second person was required when resident was weak and unsteady. The intervention for toileting was that resident #001 required extensive assistance of one staff with entire process including transferring on and off the toilet.

Resident #001 incurred a fall when they were being assisted to the toilet by one PSW. During the transfer to the toilet the resident lost their balance and was lowered to the ground by the PSW.

The post fall analysis identified the contributing factors as weakness and fatigue, and the conclusion was that the fall was due to loss of balance caused by weakness.

Interview with PSW #101 indicated that the plan of care as written may require them to consult with the registered staff for more direction.

Interview with RN #103, indicated that the plan of care as written does not provide clear direction and does not provide the PSW with any direction on how to determine weakness before initiating transfers. RN #103 was familiar with this resident and felt that during the day transferring and toileting could safely be managed by one staff, but overnight with confusion and weakness two staff would be needed to provide this care.

The Administrator and inspector jointly reviewed the plan of care. The Administrator identified that the interventions did not provide clear direction and that personal support workers may not have the skills to assess when a resident would require the assistance of the second staff member. [s. 6. (1) (c)]

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 the plan of care sets out clear directions to staff and others who provide direct care to residents, to be implemented voluntarily.

Issued on this 10th day of June, 2019

[redacted]

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

Original report signed by the inspector.