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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Feb 8, 2016	2015_393606_0020	034366-15	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

AURORA RESTHAVEN
32 MILL STREET AURORA ON L4G 2R9

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

JANET GROUX (606), MATTHEW CHIU (565), NITAL SHETH (500)

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): December 10, 11, 15, 16, 17, 18, 21, 22, 23, and 24, 2015.

The following Critical Incident inspections were inspected during the course of this RQI: CSC #026871-15, and #031891-15.

During the course of the inspection, the inspector(s) spoke with the Administrator (A), Director of Care (DOC), Associate Director of Care (ADOC), Environmental Services Manager (ESM), Assistant Food Service Manager (A)FSM, Registered Dietitian (RD), Resident Support Manager (RSM), Registered Nurses (RN), Registered Practical Nurses (RPNs),Personal Support Workers (PSWs), Dietary Aides, Housekeeping Aides, Residents, and Family members.

During the course of the inspection, the inspectors conducted observations of residents and home areas, medication administration, meal service delivery, staff to resident interactions, reviewed clinical health records, staffing schedules/assignments, minutes of Residents' Council and Family Council meetings, minutes of relevant committee meetings, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 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. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: providing residents with personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

a) An observation on an identified date and time, on an identified unit dining room revealed resident #024 was served regular textured food while the resident was asleep at the table. The inspector observed the resident was not offered any encouragement, or assistance in cutting up the food. At the same time resident #029 was sitting at the same table beside resident #024 with his/her family member who was assisting him/her to eat. Halfway through the meal service, resident #029's family member assisted resident #024 cut up his/her food and then resident began eating. The inspector did not see staff provide encouragement or assistance to the resident during the entire meal service.

A review of resident #024's plan of care indicated that the resident requires assistance with eating and staff to provide intermittent assistance with eating, cut up his/her food and one staff needed.

Interview with resident #029's family member indicated that resident #024 requires assistance with meals.

Interview with an identified PSW confirmed resident #024 requires a lot of encouragement and staff to assist him/her. Although resident #029 and his/her family member provided encouragement and assistance, it is the staff's responsibility to provide the care to the resident.

Interview with an identified RPN revealed resident #024 requires intermittent assistance and cueing during meal times and confirmed staff are responsible to cut up his/her food and not depend on resident #029's family member.

Interview with an identified dietary manager and consultant confirmed that resident #024 should have received encouragement and assistance in cutting up his/her food during the meal time as indicated in the plan of care.

b) An observation on an identified date and time, on an identified unit dining room revealed an identified resident #020 was served food but did not receive any assistance or direction from any of the staff in the dining room. It was at the end of the meal service when the inspector observed the DOC begin to feed the resident.

A review of resident #020's plan of care indicated that the resident requires assistance with eating, staff to provide extensive assistance with eating by one staff and verbally directing him/her to bring food to his/her mouth. He/she requires extensive assistance when he/she is tired.

Interview with an identified PSW confirmed resident #020 requires supervision, encouragement and extensive assistance by staff for eating. The staff required to set up assistance or physically assist and encourage him/her to eat and if it does not work than staff are required to feed the resident.

Interview with an identified RPN confirmed resident #020 requires cutting up his/her food, verbal directions and hands on assistance.

Interview with an identified dietary manager and consultant confirmed that resident should have received encouragement and assistance at the meal time as indicated in the plan of care [s. 73. (1) 9.]

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 home has a dining and snack service that includes, at a minimum, the following elements: providing residents with personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with.

On December 18, 2015, the inspector observed an identified RPN administered to an identified resident an amount of medication different from the physician's order but entered in the electronic administration record (e-mar) that he/she administered the medication as ordered.

Review of resident's medication administration records revealed the resident is to be administered the identified medication as ordered by the physician at lunch time.

Review of the home's policy indicated if medication was not given, Click N, when N is clicked, the screen will show the facility Reason Codes for No, Not Given, select from one of the available chart codes listed to determine the reason the medication was not administered. The home's facility codes are as follows: 10-drug not available; 9-Other/See Nurses Notes.

Interview with the RPN revealed that he/she administered a different dosage of the identified medication to the resident to finish the remaining amount in the vial and was going to give the remaining dosage required from a new vial.

Further interview with the RPN confirmed that he/she did not document the dosage he/she administered because he/she was planning to administer the remaining amount but this medication was not available in the home and confirmed he/she did not document accurately.

Interview with the DOC revealed the home's policy indicates if medication is not given, the registered staff is to select from the chart codes to indicate the reason the medication was not administered and confirmed that the policy was not followed. [s. 8. (1) (b)]

2. On December 18, 2015, the inspector observed an identified RPN administer an identified amount of a medication to an identified resident.

Review of resident's medication administration records revealed the resident is to be administered the identified medication as ordered by the physician at lunch time.

Review of the home's policy indicated registered staff is responsible to re-order all medications not in the pouch pack when the home supply is at five days.

Interview with an identified RPN revealed that he/she administered a different dosage of the medication to the resident to finish the remaining amount of medication in the vial and was going to give the remaining dosage required from a new vial but was not able to because the home did not have any of the medication available.

Interview with an identified RPN and the DOC revealed that it is the home's expectation that registered staff ensure medications are always available for the residents and failed to follow the home's policy. [s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were provided with food that were adequate in quantity.

An observation on an identified date and time, on an identified unit dining room revealed an identified resident was brought to the dining room, during the dessert course of the meal. The inspector observed resident was not served an adequate quantity amount of food. The resident was served half of the plate of the pureed bread, less than half the scoop of pureed beef and potato salad, and about two tablespoons of the pureed cucumber and tomato.

Interview with the (A)FSM who witnessed the above mentioned incident revealed resident was brought to the dining room late during the meal service as the resident was sleeping and confirmed the observed amount of food was available for the resident.

Interview with an identified dietary aide, PSW, RPN, and the RD confirmed the food served to the resident was inadequate and the appropriate servings should have been saved for the resident. [s. 11. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A review of the progress notes revealed an identified resident fell on an identified date, in his/her room. The fall was unwitnessed and the resident sustained no injury from the fall. A review of a fall assessment completed on an identified date for the resident indicated the resident was at low risk for falls.

A review of the home's policy and interviews with an identified RPN and ADOC confirmed the home uses a Post Fall Analsysis in PointClickCare to conduct a post-fall assessment. If a resident is at low risk for falls, it is required to conduct the Post Fall Analysis after each fall.

A review of the resident's clinical records and Post Fall Analysis indicated the above mentioned fall was the resident's first fall in the identified year, and there was no Post Fall Analysis was conducted for the resident's fall.

Interviews with an identified RPN and ADOC confirmed the resident had fallen and no post-fall assessment was conducted for the resident using the home's Post Fall Analysis as required. [s. 49. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items were offered and available at each meal and snack.

Observation on an identified date and time, on an identified unit dining room revealed nursing staff did not provide pureed tartar sauce to residents who chose pureed fish on the menu. Pureed tartar sauce was provided to residents only after the inspector brought it to the attention of the staff.

A review of the home's therapeutic menu for week two, Thursday, indicated pureed tartar sauce with pureed fish cake.

Interview with an identified dietary manager and dietary consultant confirmed that pureed tartar sauce should have been served with pureed fish cake as indicated on the menu. [s. 71. (4)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 147. Powers on inspection

Specifically failed to comply with the following:

s. 147. (4) An inspector who questions a person under clause (1) (d) may exclude from the questioning any person except counsel for the individual being questioned. 2007, c. 8, s. 147 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure an inspector who questions a person under clause (1) (d) may exclude from the questioning any person except counsel for the individual being questioned.

On an identified date and time, during an interview with the DOC, an identified staff member of the home was observed answering questions on behalf of the DOC.

The inspector requested the staff member to refrain from answering the questions for the DOC. When the staff member did not abide by the inspector's request, the inspector discontinued the interview.

Interview with the Administrator confirmed that he/she was aware of the above incident and would speak to the staff regarding the inspector's concern. [s. 147. (4)]

Issued on this 23rd day of February, 2016

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

Original report signed by the inspector.