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 # / No de registre	Type of Inspection / Genre d'inspection
Jan 11, 2018	2017_650565_0018	027430-17	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 Aurora Long Term Care Residence
32 MILL STREET AURORA ON L4G 2R9

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

MATTHEW CHIU (565), JULIEANN HING (649)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 4, 5, 6, 7, 8, 11, 12, and 13, 2017.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOCs), Convalescent Care Program Manager (CCPM), Program and Support Services Manager (PSSM), Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Residents, and Family Members.

The inspectors conducted a tour of the resident home areas, observations of medication administration, staff and resident interactions, provision of care, record review of resident and home records, meeting minutes for Residents' Council and Family Council, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **7 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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity is fully respected and promoted.

During the stage one of the Resident Quality Inspection (RQI), interview with resident #005 revealed a staff member treated him/her in an identified manner during an identified care. The resident was unable to recall the name of the responsible staff member during the interview.

Review of resident #005's Resident Assessment Instrument Minimum Data Set (RAI-MDS) assessment and plan of care revealed the resident is cognitive and required a specified assistance for the identified care. Review of the intervention and task report revealed on an identified date, Personal Support Worker (PSW) #118 gave the identified care to resident #005.

Review of the home's records indicated resident #005 stated an identified interaction between the resident and the PSW during the above mentioned care. The PSW acted in an identified manner and that made the resident sad.

Further interviews with resident #005 indicated on the identified date, he/she identified PSW #118 was the responsible staff member during the above mentioned care and reported it to the Director of Care (DOC). The resident stated further identified interactions between the PSW and the resident during the care and described PSW #118 acted in the identified manner, and resident #005 was upset.

Interview with PSW #118 indicated he/she gave the above mentioned care to resident #005 on the identified date. The PSW stated identified interactions between the resident and the PSW during the care and denied acted in the above mentioned identified manner towards the resident.

Interview with the DOC indicated the home identified PSW #118 who provided the above mentioned care to resident #005 on the identified date. The resident had received the same care assistance from various staff members on different dates and the only care concerned the resident was with PSW #118 on the identified date. The DOC further indicated during the above mentioned care, resident #005 was sad as a result of how he/she was treated by PSW #118. The DOC indicated PSW #118 should focus on the resident's response and be more compassionate when providing care to the resident, and should not demonstrate the identified interaction towards the resident. The DOC

stated although there was no other witnesses, the home acknowledged that resident #005 was not treated with respect by PSW #118 during the above mentioned care. [s. 3. (1) 1.]

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 resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity is fully respected and promoted, 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. (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 care set out in the plan of care is provided to the resident as specified in the plan.

Resident #003 triggered from stage one of the RQI for a specified health condition.

A review of resident #003's plan of care indicated that he/she is at a specified health risk and had an identified usual fluid intake. Staff are to send a referral to the Registered Dietitian (RD) when the fluid intake is at an identified level.

Record review of resident #003's documented intake for an identified three month period indicated that the resident's fluid intake was at the identified level on multiple identified dates.

Record review of progress note type "dietary referral note" covering the above mentioned three month period indicated no referral had been sent to the RD when resident #003's fluid intake was at the identified level.

Interview with the RD indicated that the care set out in resident # 003's plan of care was to direct staff member to send a referral to the RD when the resident's intake was at the identified level. The RD further confirmed that he/she had never received a dietary referral for resident #003 when his/her intake was at the identified level as above indicated.

Interview with Assistant Director of Care (ADOC) #107 stated that no referral had been sent to the RD during the identified three month period, and a referral should have been sent when the resident #003's intake was at the identified level. The ADOC further confirmed the care set out in resident #003's plan of care had not been provided to the resident as specified in the plan. [s. 6. (7)]

WN #3: 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 that any plan, policy, protocol, procedure, strategy or system that the licensee is required by the Act or Regulation to have instituted or otherwise put in place was in compliance with and is implemented in accordance with applicable requirements under the Act.

According to Ontario Regulation 79/10 section 50. (2) (a) every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours.

Record review of the home's policy titled Skin Care Program Overview revised January 2013, July 2014, November 2014, November 2015, policy #LTC-CA-WQ-200-08-01 directed the registered staff to complete a skin assessment using the skin-initial Skin and Wound assessment in Point Click Care (PCC):
- Within 24 hours following admission,
- On readmission following a leave of absence greater than 24 hours,
- Following any readmission from hospital,
- With any significant change in status, and
- With any newly identified alteration in skin integrity

Resident #006 triggered from stage one of the RQI for skin and wound related to an identified health condition. Review of the identified records indicated resident #003 was at a specified health risk. Review of resident #006's progress notes indicated the resident had been transferred to hospital on an identified date and time and returned on the next day at an identified time. The home's skin policy mentioned above did not provide any direction on what skin assessment should have been completed upon the return of resident #006, who was identified at the specified health risk, from hospital.

Interviews with Registered Nurse (RN) #111 and ADOC #106, indicated that the home's skin policy #LTC-CA-WQ-200-08-01 did not provide any direction on what skin assessment should have been completed for resident #006 upon his/her return from hospital on the identified date after being away for less than 24 hours. [s. 8. (1) (a),s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The license has failed to ensure that each resident who is incontinent receives an assessment that includes identification of casual factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

Resident #007 triggered from stage one of the RQI for continence care and bowel management related to a specified health condition.

Record review indicated that resident #007 was admitted on an identified date. The RAI-MDS admission assessment indicated resident #007 had a specified level of incontinence. Further review of the RAI-MDS assessment dated an identified date three months later indicated the resident's continence status had deteriorated two levels.

Record review and staff interviews revealed that a resident who is incontinent will receive a continence assessment using the home's identified continence assessment instrument in PCC. Further review of the assessment records indicated this continence assessment had not been completed for resident #007 when he/she was admitted and when his/her continence status had deteriorated two levels.

Interviews with RN #105 and the ADOC #106 indicated that resident #007 had the specified level of incontinence when he/she was admitted, and the resident's continence status had deteriorated two levels three months later as above mentioned. The staff members confirmed that the resident did not receive the identified continence assessment on admission and three months after admission, as required. [s. 51. (2) (a)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that if the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing.

A review of the Ministry of Health and Long-Term Care (MOHLTC) Family Council Questionnaire revealed that the home did not provide response to the Family Council in writing within 10 days of receiving the advice related to concerns or recommendations regarding the home or services.

Review of the Family Council meeting minutes revealed two identified concerns were raised to the home on two identified dates.

Further review of further Family Council meeting records revealed no evidence of written response was given by the home to the Family Council related to the above mentioned concerns.

Interview with the Family Council indicated the above mentioned concerns were brought up during the Council meetings. The home had appointed the Director of Social Services (DSS) to assist the Council, and if a concern was raised to the home during a meeting, the DSS would bring the concern back to the home's management. The Family Council would receive a verbal follow-up from the DSS in the following meeting. The Family Council indicated they had received verbal response to the above mentioned concerns but no written response was given to the Family Council by the home.

Interview with Programs and Support Services Manager (PSSM) #113 indicated that he/she was the former DSS who assisted the Family Council. PSSM #113 indicated the home has a Family Council response form for responding to the Family Council in writing. PSSM #113 was aware that within 10 days of receiving the Family Council's concerns, the home should response to the Council in writing, and sometimes that was being done by email. PSSM #113 further stated that depending on what the concern is, he/she may give the Family Council a verbal response in the following Council meeting. PSSM #113 confirmed that no written response was given to the Family Council for the above mentioned concerns. [s. 60. (2)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that the copies of the inspection reports from the past two years for the long-term care home were posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

Observations during the initial tour of the home on December 4, 2017, revealed that the home's last two years RQI inspection reports #2015_393606_0020 issued on February 8, 2016, and #2017_357648_0002 issued on February 17, 2017, were not posted in the home.

On December 5, 2017, the inspector inquired with the DOC if there were any other areas in the home where information was posted. The DOC took the inspector to two additional home areas and the inspector observed no inspection reports were posted.

Interview with the DOC stated that he/she did not see the reports posted in the home, and the Administrator confirmed that the two reports #2017_357648_0002 and #2015_393606_0020 were not posted as required. [s. 79. (3) (k)] (649) [s. 79. (3) (k)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

Observation of a medication administration on an identified date on an identified resident home area revealed two identified personal items were in the narcotic drawer of the medication cart.

Interview with RPN #103 revealed that the two identified personal items should not be stored in the narcotic drawer and immediately removed the items.

Interview with DOC confirmed that the identified personal items should not have been stored in the narcotic drawer of the medication cart. [s. 129. (1) (a)]

Issued on this 25th day of January, 2018

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

Original report signed by the inspector.