Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 2, 2020	2020_832604_0002	021978-19, 022883-19, 023222-19, 000695-20	Critical Incident System

Licensee/Titulaire de permis

Chartwell Master Care LP
7070 Derrycrest Drive MISSISSAUGA ON L5W 0G5

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

SHIHANA RUMZI (604), MOSES NEELAM (762), ROMELA VILLASPIR (653)

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): January 7, and 8, February 4, 5, 6, 7, 10, 11, 12, 13, 14, 18, and 20, 2020.

During this inspection intakes related to Critical Incident System (CIS) report was inspected related to two intake log related to fall with injury and one intake related to elopement resulting in injury.

During the course of the inspection, the inspector(s) spoke with the Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Worker (PSW), Occupational Therapy (OT), and Brook Jane Staffing Agency, Physiotherapy (PT).

During the course of the inspection, the inspector(s) conducted observations of staff to resident interactions, provision of care, resident health records, home's critical incident logs, and home's relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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 :

The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

The home submitted Critical Incident System (CIS) report indicating an incident had occurred causing injury to resident #005 for which the resident was taken to hospital which resulted in a significant change in the residents health status.

A review of resident #005's plan of care under an identified care focus did not consist of clear direction to staff as to how to provide the care.

In separate interviews with ADOC #122, RPN #102 and #134, and PSW #129 indicated staff would refer to a resident's care plan to gather information related to the resident care needs. The staff reviewed resident #005's plan of care and stated there was no clear direction as to how to provide the care.

2. The Ministry of Long-Term Care (MLTC) ACTIONline received a complaint and the complainant indicated an identified care was not provided by the home when requested by the complainant as a result of resident #014's presented with identified behaviors. The complainant stated they notified the Long-Term Care Home (LTCH) of the residents' atypical symptoms and as a result the resident was transferred to hospital for further care.

In an interview Substitute Decision Maker (SDM) #115 indicated resident #014 had an identified diagnoses and was treated prior to admission to the LTCH.

A review of resident #014's chart was carried out and it was noted the resident was assessed in the LTCH and hospital and no diagnosis were made.

A review of resident #014's plan of care consisted of focuses related to an identified assessment and a part of the interventions indicated history of an identified diagnosis. The plan of care did not consist of interventions as to how the staff where to assess and monitor the resident related to their diagnosis.

In separate interviews with RN #119, NP #120, and RN #124, indicated the SDM stated resident #014 had a history of an identified diagnosis. RN #124 reviewed resident #014's care plan and indicated there was no clear direction as to how the resident is to be

monitored for the identified diagnosis.

In an interview Assistant Director of Care (ADOC) #135 reviewed resident #014’s plan of care, progress notes, resident records, and acknowledged the plan of care did not give clear direction to staff related to interventions on monitoring resident #014 for symptoms related to an identified diagnosis.

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 the resident, to be implemented voluntarily.

Issued on this 2nd day of March, 2020

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

Original report signed by the inspector.