Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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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
Dec 4, 2020	2020_832604_0014	016698-20, 019893-20	Complaint

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)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 23, 24, 25, 26, 30, and December 1, 2020.

During the course of the inspection complain intakes related to infection control and previsions of care was inspected.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Nurse Supervisor (NS), Programs and Support Services Manager (PSSM), Registered Nurse (RN), and Personal Support Worker (PSW).

During the course of the inspection the inspector reviewed resident health records, observed staff to resident interaction, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Infection Prevention and Control
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 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. 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).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to respect and promote residents right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity.

The Ministry of Long-Term Care (MLTC) ACTIONline received a complaint which stated the residents dignity related to preference was not respected by the home. Interviews where conducted with Personal Support Worker Staff (PSW) and Programs and Support Services Manager (PSSM) who acknowledged the residents dignity was not respected related to the residents preferences.

Sources: Review of intakes, interviews with the complainants, PSW and PSSM interview.

2. The licensee has failed to ensure that the licensee fully respected and promoted residents right to receive visitors of their own choice and consult in private without interference.

The MLTC ACTIONline received a complaint which stated the home had not offered an alternate method of visiting with the resident though the COVID-19 pandemic as they had concerns related to resident’s wellbeing and wanted to visit the resident. In an interview the PSSM stated during the pandemic the home offered webx, face time, and zoom calls as an alternate method of visitation between the resident and families. An email was sent out to families encouraging them to communicate with their loved once through alternate technologies. The PSSM acknowledged that the home did not communicate with the families the alternate options provided by the long-term care home (LTCH) to carryout visits with the residents and the Resident’s Bill of Rights to receive visitors where not followed.

Sources: Review of intakes, interviews with the complainants, family information email, and PSSM #107 interview.

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 licensee
-fully respected and promoted residents right to be treated with courtesy, respect, and in a way that fully recognizes their individuality and respects their dignity
-to receive visitors of their own choice and consult in private without interference, 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 :

The licensee has failed to ensure the care set out in the plan of care was provided to residents as specified in the care plan related to oral care.

A review of the residents' care plan indicated the resident requires assistance with personal hygiene with identified interventions. Observations where carried out for the resident and it was observed that the set interventions where not carried out as indicated in the residents care plan. The PSW and RPN acknowledged that the care was not followed as per the care plan.

Sources: Review of intakes , residents care plan, observations, and interview with PSW and RPN.

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Issued on this 10th day of December, 2020

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

Original report signed by the inspector.