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

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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
Jul 29, 2021	2021_784762_0022	025245-20, 025702-20, 002234-21, 003026-21, 003398-21, 004356-21, 006336-21, 009279-21	Critical Incident System

Licensee/Titulaire de permis

Chartwell Master Care LP, by its general partner, GP M Trust, by its sole trustee, Chartwell Master Care Corporation
c/o 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

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): July 19-23, 2021

The following intakes were completed in this Critical Incident System (CIS) inspection:
- Logs/CIS's related to fall incidents resulting in injuries

PLEASE NOTE:
- Written Notification and Voluntary Plan of Correction (VPC) related to LTCHA, 2007, c.8, s. 6. (7) was identified in inspection # 2021_784762_0021 and has been issued in this report.
- Written Notification related to LTCHA, 2007, c.8, s. 5 was identified in inspection # 2021_784762_0021 and has been issued in this report.

The following intakes were completed in this Critical Incident System Inspection:
Logs/CIS's related to falls

During the course of the inspection, the inspector(s) spoke with the Administrator, Interim Environmental Services Manager, IPACcoordinator, Associate Director of Care (ADOC) Director of Care (DOC), Registered Nurses (RNs), Agency Registered Practical Nurses (RPNs), Registered Practical Nurses (RPNs), Housekeeping Staff and Personal Support workers (PSWs)

During the course of the inspection, the inspector toured the home, observed IPAC practices, provision of care, staff to resident interaction, reviewed clinical health records, staffing schedule, air temperature records, the home's investigation notes, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Safe and Secure Home
Skin and Wound Care

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

4 WN(s)
2 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 PSW #110 collaborated with Agency RPN #111 in the assessment of resident #007 upon re-admission to the home from the hospital.

The home had submitted CIS to the Director related to resident #007 sustaining an injury from an unknown cause.

A review of resident #007's clinical health records indicated they were re-admitted to the home on a certain date, and a re-admission assessment was not completed by Agency RPN #111. An interview with PSW #110 and a review of the home's investigation notes indicated that during care, the PSW noticed an injury to the resident, and the resident also complained of pain. The PSW confirmed they did not report this to Agency RPN #111 because they presumed that the nurse would have done their own assessment. RPN #109 indicated, on the following day, when they were administering morning medications, they noticed the injury. The resident also complained of pain while they were being assessed by the RPN and the Physiotherapist. Further review of the resident's clinical health records indicated the Nurse Practitioner assessed the resident and ordered for an intervention to be done, which later confirmed the injury. The lack of staff collaboration resulted in the delay in assessment of the injury, and the resident's pain was not addressed in a timely manner.

Sources: Review of resident #007's clinical health records; Interviews with RPN #109, PSW #110, and the DOC. [s. 6. (4) (a)]

2. The licensee has failed to ensure that resident #007 received extensive assistance with one staff member for care, as required by their care plan.

The home had submitted CIS to the Director related to resident #007's unwitnessed incident, which resulted in an injury.

A review of resident #007's care plan, indicated they were at high risk for this incident, and they required extensive assistance with one staff for care. In an interview RPN #109 indicated, at the time of the incident, they heard a loud sound from the resident's room, and upon arrival, the incident had occurred. The RPN confirmed that at the time of the incident, the resident was alone, while Agency PSW #112 was in the hallway taking a clean brief from their care cart. Further review of the resident's clinical health records indicated the resident complained of pain post-incident, and the Nurse Practitioner ordered for an intervention to be done, which later confirmed the injury. Separate interviews with RPN #109 and the DOC #107 confirmed that Agency PSW #112 should have stayed with the resident throughout the care process, as required by their care plan.

Sources: Review of resident #007's clinical health records; Interviews with RPN #109, and the DOC. [s. 6. (7)]

3. The licensee has failed to ensure that resident #008 had certain interventions as per the plan of care.

In separate observations, it was noted that resident #008, did not have certain interventions. A review of the resident care plan indicated that the resident required to have a specific intervention at the bed side for the prevention of incidents. In separate interviews, PSW #123 and ADOC #119, indicated the resident was required to have this specific intervention as per the plan of care, and the intervention was not present. As a result, the resident was at risk for an incident as the intervention was not present as per the plan of care.

Sources: Observations by inspector #762; care plan; interviews with PSW #123 and ADOC #119

The licensee has failed to ensure that the care set out in the plan of care for resident #002 was provided to the resident as specified in the plan

In an observation, resident #002 was noted to have a nutrition item in front of them for a certain period. It was noted that multiple staff were monitoring and passing by the resident, however, not assisting the resident. The resident was noted to have a little bit of this item during the time. A review of the resident care plan indicated that the resident required assistance for encouragement. In an interview, RPN #120 indicated that the resident required encouragement and that the staff were monitoring the resident and would provide occasional assistance. ADOC #119 indicated based on the care plan, required assistance for encouragement for this nutrition item and that the resident was able to manage independently with supervision. By not consistently providing assistance, the resident was at risk for not completely eating their nutritional item.

Sources: Care plan; Observation and interviews with RPN #110 and ADOC #119. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
3. Every designated cooling area, if there are any in the home. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature was measured and documented in writing in every designated cooling area in the home.

During an interview, the interim Environmental Services Manager (ESM) confirmed that the home's designated cooling areas on each unit were the dining room and lounge. A review of the home's "Indoor Air Temperature and Humidex Monitoring Record" for multiple months, and separate interviews with four Housekeepers (HKs), revealed that the temperatures in all designated cooling areas were not measured and documented. By not measuring and documenting the air temperatures in the designated cooling areas in the home, staff may not be able to identify when temperature concerns arise.

Sources: Review of the home's air temperature records; Separate interviews with the ESM, and HKs. [s. 21. (2) 3.]

2. The licensee has failed to ensure that the temperatures required to be measured under subsection (2), were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

An interview with the ESM, and a review of the home's "Indoor Air Temperature and Humidex Monitoring Records" for multiple months, revealed the air temperatures were only measured and documented once daily, and twice daily between a five day period. Further review of records, revealed the air temperatures were measured and documented three times daily for a thirteen day period, however, only one home area demonstrated complete documentation of air temperatures taken in resident rooms, and corridors. By not measuring and documenting the required air temperatures once every evening or night, staff may not be able to identify when temperature concerns arise.

Sources: Review of the home's air temperature records; Interview with the ESM. [s. 21. (3)]

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 that the temperature was measured and documented in writing in every designated cooling area in the home, and that the temperatures required to be measured under subsection (2), were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe environment related to IPAC measures specified in Directive #3, regarding the appropriate use of PPE by essential visitors.

The Chief Medical Officer of Health (CMOH) implemented Directive #3, which has been issued to Long-Term Care Homes (LTCHs), and sets out specific precautions and procedures that homes must follow to protect the health of residents and address the risks of an outbreak of COVID-19 in LTCHs.

During an observation conducted by Inspector #653, it was noted that a room was on droplet/ contact precautions. A staff member was in full PPE, and there were two essential visitors inside only wearing face masks. A review of clinical health records indicated that the resident in this room was placed on droplet/ contact precautions pending COVID-19 swab results. An interview with the Assistant Administrator indicated the two essential visitors were supposed to wear full PPE inside the droplet/ contact room. During an interview, the IPAC Co-ordinator acknowledged the risk associated to the essential visitors not wearing full PPE, was potential for transmission of infection.

Sources: Inspector #653's observation; Separate interviews with the Assistant Administrator, and the IPAC Co-ordinator.

The licensee has failed to ensure that the home was a safe environment related to IPAC measures specified in Directive #3, regarding the appropriate use of PPE by staff.

While conducting the initial tour of the facility, it was noted that PSW #122 was assisting a resident in a droplet precaution room, without eye protection. The PSW staff was within two meters of the resident. The PSW indicated that the staff are required to wear eye protection when going into resident rooms with droplet precautions. In an interview, IPACcoordinator #100 indicated that the staff are expected to wear eye protection in a droplet precaution room. By not wearing eye protection in a resident room with droplet precaution, the resident was put at risk for the spreading of COVID-19.

Sources: Observation on Jul 19, 2021 at 14:27; Directive #3; Interviews with IPACcoordinator #100 and PSW #122 [s. 5.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that Agency RPN #113 documented resident #006's assessment post an incident.

A review of resident #006's clinical health records indicated they had an incident, and was found in their washroom. Further review of progress notes and an interview with Agency RPN #113 indicated the resident was assessed post-incident and an assessment was started. However, a review of the resident's chart with RPN #109 indicated that the assessment was missing parts of the documentation on a flow sheet. An interview with the DOC indicated that the registered staff were to document the the assessment on a flow sheet. The lack of documentation increased the potential for registered staff to overlook changes in the resident's status post-incident.

Sources: Review of resident #006's clinical health records; Interviews with Agency RPN #113, the DOC, and other staff. [s. 30. (2)]

Issued on this 4th day of August, 2021

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

Original report signed by the inspector.