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
Feb 10, 2022	2022_882760_0003	002105-21, 004516-21, 005148-21, 011590-21, 011797-21, 013951-21, 017356-21, 018776-21, 000876-22	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

JACK SHI (760), ERIC TANG (529)

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 31, February 1, 2, 3, 4, 7, 8, 2022.

The following intakes were completed in this critical incident inspection:

Two logs were related to a fall;
Four logs were related to a significant change in condition;
Two logs were related to an allegation of resident abuse;
A follow up log to Compliance Order (CO) #001, O. Reg 79/10 s. 26 (3), related to dining and nutrition, issued under inspection #2021_875501_0022, on Oct 19, 2021, with a compliance date of December 31, 2021, was inspected.

During the course of the inspection, the inspector(s) spoke with A nursing unit clerk, the Registered Dietitian (RD), a Physician, the Nurse Practitioner (NP), the Administrator, an agency Registered Practical Nurse (RPN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Associate Director of Care (ADOC) and the interim Director of Care (DOC).

During the course of the inspection, the inspector toured the home, observed Infection Prevention and Control (IPAC) practices, observed care activities on the units, reviewed relevant policies and procedures and reviewed resident records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

- **4 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 26. (3)	CO #001	2021_875501_0022	760

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).

Findings/Faits saillants :

1. The licensee failed to ensure that agency RPN #109 collaborated with RPN #106 to assess and monitor resident #001 after they had sustained a fall.

A Critical Incident Systems (CIS) Report was submitted by the home related to a fall that this resident sustained and resulted in an injury. According to the progress notes, a PSW had found the resident after they sustained a fall. The PSW stated when they found the resident, they called RPN #106 to assess the resident, but the RPN was busy on a different unit, so agency RPN #109 was called from another unit to come to assess the resident. The agency RPN stated they had performed an assessment and provided interventions to the resident. The agency RPN then called RPN #106, who instructed the agency RPN to go back to their unit and that they will manage the incident once they finish up with their work with the resident on the other unit. The agency RPN confirmed they did not come back onto the unit to assess the resident because of the instructions RPN #106 provided and the PSW was monitoring the resident at this time. RPN #106 arrived to assess the resident at a later time and had provided further interventions at that time.

According to the progress notes, the resident then sustained a significant change in their condition after this fall. The NP stated that a registered staff should have been monitoring and assessing the resident after their fall. The interim DOC added that there was a miscommunication between the agency RPN and RPN #106 when they attempted to collaborate after this resident’s fall. When the registered staff failed to properly assess, collaborate and monitor related the resident’s condition after a fall, it may have resulted in missed opportunities to provide timely interventions to the resident.

Sources: Resident #001’s progress notes; Interviews with a PSW, agency RPN #109, RPN #106, a NP, the interim DOC and other staff. [s. 6. (4) (a)]

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 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 othe, 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 the falls prevention policies and procedures included in the required Falls Prevention Program were complied with, for resident #001.

In accordance with O.Reg. 79/10, s. 48(1), the licensee was required to ensure that a falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented.

Specifically, staff did not comply with the home's policy and procedure “Resident Falls Prevention Program", dated June 2019. The policy stated a that head injury routine (HIR)/neurological assessment will be initiated for 48 hours for unwitnessed falls and/or with falls with head injuries.

A CIS report was submitted by the home related to a fall that this resident sustained and resulted in an injury. According to the progress notes, the resident had sustained an unwitnessed fall with an injury. A review of the resident’s chart did not demonstrate that a HIR was completed related to this resident’s fall. Agency RPN #109 stated they were instructed by RPN #106 to go back to their unit after the agency RPN initially performed the assessment on the resident. The agency RPN confirmed they did not complete a HIR as a result of this direction from RPN #106. According to the progress notes, the resident was diagnosed with an injury after their fall. The NP stated that the HIR should have been completed by the registered staff to monitor this resident’s condition, after their fall. The HIR is the home’s clinical tool to ensure staff can take the appropriate actions when a resident sustained an unwitnessed fall and/or with a head injury and failing to do so resulted in missed opportunities to provide time sensitive appropriate actions.

Sources: The home’s policy titled, “Resident Falls Prevention Program", dated June 2019; Resident #001’s progress notes, Interviews with agency RPN #109, RPN #106, the NP and other staff. [s. 8. (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 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, (b) is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a weekly skin assessment was completed related to a resident's altered skin integrity.

A Critical Incident Report was submitted to the Director informing a resident had sustained an injury and a significant change in condition.

A review of the resident's electronic health records revealed that they had developed altered skin integrity from their injury. The altered skin integrity continued for a period of time.

A review of the home's policy titled Wound Care Treatment with a last revision date of December 2017 indicated staff to complete an initial Skin and Wound baseline assessment and thereafter, to complete the assessment in the same system every seven days.

An interview with the RPN and the Interim Director of Care confirmed this resident's altered skin integrity was not assessed within a seven day period.

The risk of not completing weekly skin and wound assessment may delay the healing of the altered skin integrity for the resident.

Sources: The CIS report, a resident's electronic health records, home's policy titled Wound Care Treatment (dated December 2017), and staff interviews with two RPNs, and the Interim Director of Care. [s. 50. (2) (b) (iv)]

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, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that an allegation of staff to resident verbal abuse directed towards a resident was not immediately reported to the Director.

A Critical Incident Report was submitted to the Director stating that a resident was allegedly abused by a PSW.

A review of the home's internal investigative records revealed that correspondence was sent to the home related to an allegation of staff to resident abuse. The assistant director of care confirmed they had received and reviewed the allegation. They confirmed that the Director was not informed at the time of their review of the allegation and had notified the Director on the following day.

Sources: A CIS report, home's internal investigative records for a resident, and a staff interview with the Assistant Director of Care. [s. 24. (1)]

Issued on this 10th day of February, 2022

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

Original report signed by the inspector.