Ontario

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

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l’inspection	Log # / No de registre	Type of Inspection / Genre d’inspection
Jun 14, 2021	2021_887111_0011	006252-21	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 Ballycliffe Long Term Care Residence
70 Station Street Ajax ON L1S 1R9

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

LYNDA BROWN (111)

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): May 28, 30 and June 1, 2021.

A complaint related to nutritional needs and Infection Prevention and Control (IPAC) was inspected concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Registered Dietitian (RD), Dietary Aid (DA), Housekeeping (HSK), Food Service Manager (FSM), Administrative Assistant (AA) and residents.

During the course of the inspection, the inspector(s): toured the home, observed IPAC practices, observed dining service, reviewed resident health records, screening records of staff, visitors and residents, diet sheets and the home's policies for Food and Nutrition Services, Referrals to Dietitian.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Nutrition and Hydration
Safe and Secure Home

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 O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

The licensee has failed to ensure the nutrition care and hydration program included the implementation of interventions to mitigate and manage the identified risks related to nutrition care and dietary services and hydration for resident #001.

A complaint was received from the family of resident #001 regarding the dietary management of their specified diagnosis. The resident was admitted with a specified diagnosis, included specified medications to manage the diagnosis and a regular diet. The resident’s pre-admission laboratory values related to the specified diagnosis were stable. There were no identified dietary restrictions in the resident's nutritional care plan related to the resident’s specified diagnosis. A food and fluid intake study was initiated a number of days after admission and to be completed for a specified number of days, due to the residents poor intake. The intake study had only one meal completed and the remaining areas were left incomplete, for the entire duration of the study. A referral was sent to the Registered Dietitian (RD) for an alteration in skin and the RD ordered a specified supplement for the alteration in skin and decreased food intake, despite documenting in the resident's progress notes they would be started on a different supplement for their specified diagnosis. The resident's laboratory values became

elevated a number of days after admission and continued to elevate for a number of weeks. Despite the resident's elevated laboratory values, and with the physician ordering additional and increased specified medications to manage their specified diagnosis, the RD initiated dietary changes as per the family request, contrary to their specified diagnosis, and without documented health teaching with the family. A number of days later, a referral was sent to the RD, regarding the resident's elevated laboratory values and request to change the residents supplement. The RD changed the supplement at that time to one for their specified diagnosis, and died a number of days later.

Diet list sheets were used by dietary and PSW staff to identify a resident's diet and any dietary restrictions, but did not include a specified diagnosis. A Dietary Aid (DA) indicated they had to rely on the nurse to tell them which residents had a specified diagnosis. The Food Service Manager (FSM) indicated as per the home’s policy, all residents were given regular diets, regardless of diagnosis, but included specified dietary restrictions for residents with the specified diagnosis and/or as per resident/family request. The RD indicated residents with a specified diagnosis had specified dietary interventions and nursing staff were to submit a referral to the RD when the residents laboratory values increased. The RD indicated as part of their assessment, they reviewed residents laboratory values and if noted to be unstable or elevated, they would adjust the resident's dietary restrictions accordingly. The RD indicated if the resident required the use of a supplement, they would order a specified supplement. The RD confirmed resident #001 was eating poorly, had elevated laboratory values and they had ordered the specified supplement. Failure to ensure that the resident’s nutritional care included additional interventions implemented to mitigate and manage their identified risks related to specified diagnoses, resulted in an increased risk of related complications.

Sources: resident #001 care plan, Medication Administration Records (MAR), progress notes, Blood sugars, prescriber order forms, pre-admission notes, lab reports, dietary referrals, nutritional assessments, clinical notes, daily food and intake record and Food and Nutrition Services policy (LTC-CA-WQ-300-05-03) updated June 2020 and interview of staff.

2. The licensee has failed to ensure that the nutrition care and hydration programs include the implementation of interventions to mitigate and manage the identified risks related to nutrition care and dietary services and hydration for resident #002.

Resident #002 was admitted with specified diagnoses, a specified diet and a number of dietary restrictions. The resident’s diet sheet did not include the resident's specified

diagnosis, did not include the specified diet or the specified dietary restrictions. The resident's care plan also had different specified items the resident was to receive and not to receive but the diet sheets did not include those either. The residents laboratory values were noted to be unstable, requiring ongoing changes to the resident’s medications during a specified month. The Inspector observed resident #002 during a lunch meal and the resident was provided with food and fluids that were contrary to their nutritional care plan. Failing to provide the resident with the nutrition and hydration interventions as per their identified risks, may lead to further complications related to their diagnoses.

Sources: observation, interview of resident #002, care plan, blood sugar records, Medication Administration Record (MAR) and diet sheet for resident #002 and interview of staff.

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 programs include, (a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; (b) the identification of any risks related to nutrition care and dietary services and hydration; (c) the implementation of interventions to mitigate and manage those risks, to be implemented voluntarily.

WN #2: 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 :

The licensee has failed to ensure that the home is a safe and secure environment for its residents, specifically regarding the active screening process under Directive #3.

On three separate dates, the Inspectors were not actively screened upon entry to the home. The screener indicated that Inspectors did not require active screening. The Visitor COVID-19 Screening Logs for those dates did not identify the Inspectors as visitors on two of the dates and the third date had a line drawn through the screening questions. The DOC indicated that the screeners had misunderstood their direction related to screening of inspectors. Failing to actively screen all visitors entering the Long Term Care (LTC) home can lead to the spread of COVID-19 infections in the home.

Source: observations, Directive #3: COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7, updated May 4, 2021, Visitor COVID-19 screening Logs and interviews of staff.

Issued on this 15th day of June, 2021

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

Original report signed by the inspector.