Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 29, 2015	2015_303563_0026	016048-15	Resident Quality Inspection

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

Long-Term Care Home/Foyer de soins de longue durée

Chartwell Aylmer Long Term Care Residence
465 TALBOT STREET WEST AYLMER ON N5H 1K8

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

MELANIE NORTHEY (563), HELENE DESABRAIS (615), NANCY JOHNSON (538)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): July 14 - 17 and 20 - 23, 2015

The following Critical Incident inspections were conducted concurrently during this inspection:
Log # 002623-15/CI 2740-000001-15: resident to resident abuse
Log # 003234-15/CI 2740-000003-15: resident to resident abuse
Log # 005298-15/CI 2740-000005-15: staff to resident abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Regional Manager, two Registered Nurses, two Registered Practical Nurses, five Personal Support Workers (PSWs), the PSW Coordinator, the Behavioural Supports Ontario PSW, forty Residents and three family members.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed meal and snack service, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

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

Record review of the current plan of care on July 20, 2015 revealed interventions where by Resident # 047 had a specific transfer plan in place using a specific type of transfer.

Room observation for Resident # 047 revealed the transfer specified on the logo system differed from the specific transfer documented in the current care plan.

Staff interview with two Personal Support Workers (PSWs) revealed staff no longer use the specific transfer for Resident # 047 identified in the care plan and confirmed PSWs refer to the logo system and the PSW Kardex for interventions related to care and services. Both PSWs confirmed the plan of care did not provide clear directions related to the type of transfer used for this resident.

Interview with the Director of Care on July 20, 2015 at 1330 hours confirmed it was the home's expectation that the plan of care set out clear directions to staff and others who provided direct care to the residents. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Observation of Resident # 023 revealed the resident received medication in a public area of the home. The Registered Practical Nurse received verbal consent from Resident # 023 to administer the medication in the shared dining room.

Record review of the current care plan for Resident # 023 revealed preferences to have medications administered in a public area of the home was absent from the care plan.

Staff interview with a Registered Practical Nurse confirmed that Resident # 023 preferred medication administration in the dining room and that Resident # 023 did not have preferences related to medication administration in a public area of the home as part of the care plan.

Staff interviews with the Director of Care on July 20, 2015 at 1400 hours confirmed that it was the home's expectation to have residents' preferences included in the care plan. [s. 6. (2)]

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 set out clear directions to staff and others who provided direct care to the resident and that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that for each resident who was incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Record review of the census tab in PointClickCare for Resident # 006 revealed the resident was admitted in 2013. Review of the MDS under section H revealed Resident #006 was incontinent on admission. There was no documented evidence of a continence assessment completed.

Record review of the “Admit/Discharge To/From Report” by Inspector # 563 revealed

there were multiple admissions where by the Minimum Data Set (MDS) Section H related to continence revealed multiple residents were incontinent on admission. Seventy one percent did not have a Ont - Bladder Continence Assessment and/or Ont - Bowel Function assessment completed.

Record review of the MDS Assessment Section H and review of the Resident Assessment Protocols (RAPs) revealed the bladder/bowel continence assessment did not identify causal factors, patterns, type of incontinence and potential to restore function with specific interventions for bowel continence and the residents were not assessed according to these factors.

Staff interview with the Director of Care (DOC) revealed the home used the MDS Section H and the RAP summary as the bladder/bowel continence assessment and a note would be made in the RAPs summary as needed. Further discussion with the DOC confirmed the MDS Section H and RAP summary was the only continence assessment completed for Residents #006, 010, 011, 012, 013, 014, 015, and 016 and there was no other bladder/bowel assessment completed.

Staff interview with the DOC confirmed it was the expectation of the home that for each resident who was incontinent, that the residents received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. [s. 51. (2) (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 for each resident who was incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence, to be implemented voluntarily.

Issued on this 29th day of July, 2015

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

Original report signed by the inspector.