Ontario

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Nov 4, 2016	2016_258519_0016	029159-16	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

SHERRI GROULX (519), ADAM CANN (634), INA REYNOLDS (524)

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): October 27, 28, 31, Nov 1, 2, 2016

The following intake was included within the Resident Quality Inspection (RQI): #030768-16 (2740-000012-16) related to a critical incident which involved a resident injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Programs Manager, the Business Manager, the Corporate Consultant, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Families and Residents.

The inspectors toured the home, observed medication passes, medication storage area and care provided to residents, reviewed medication records and plans of care for specified residents, reviewed policy and procedures, observed recreational programming, staff interaction with residents and general maintenance and cleaning of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **1 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	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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the provisions of the care set out in the plan of care were documented.

A Critical Incident Systems Report (CIS) was submitted by the home to the Ministry of Health and Long Term Care on a specific date. The report stated that a resident was involved in an incident that left the resident injured.

A record review was completed of the resident's plan of care in Point Click Care (PCC). The care plan stated that the resident required to be monitored by staff to ensure the resident's safety.

An interview was conducted with a Personal Support Worker (PSW), who stated that staff were monitoring the resident closely. The PSW stated that when a resident was being checked, the PSW's were to complete the monitoring form in the Behavioral Monitoring Binder. The PSW looked in the behavioral binder as well as in the resident's hard copy chart and could not find a completed monitoring sheet for the time of the incident.

An interview was conducted with the Director of Care (DOC), who stated that the monitoring sheet was not completed for the time of the incident as she could not locate this documentation.

The licensee failed to ensure that the provision of increased monitoring for the resident was documented. [s. 6. (9) 1.]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

During Stage One observations of the Resident Quality Inspection (RQI), it was noted that a resident was using a Personal Assistance Services Device (PASD). This was observed on two subsequent dates as well. This PASD was recommended by the Occupational Therapist on a specific date to assist in the resident's activities of daily living (ADL).

Upon interview with the resident, it was stated that they used the PASD to assist them in one of their ADLs.

Upon interview with a Registered Practical Nurse, it was stated that the PASD had assisted the resident in one of their ADLs, but that they could remove it on their own and it had been found in various places on the home area.

The home's policy titled, "Resident Safety and Risk Management - PASD", policy number LTC-CA-ON-200-07-18, date of revision July 2014, stated under "Procedures #5 that each PASD in use will be care planned for in the resident's care plan. The care plan is to include:
a. What the device is
b. What ADL the device supports or assists with
c. When the device is to be applied
d. When it is to be removed
e. Cleaning and care instructions"

Upon interview with Administrator and the Director of Care, it was stated that it would be the expectation of the home that the PASD the resident required for assistance with their ADLs would have been included in their plan of care, and that the care plan should have been updated to reflect that. [s. 6. (10) (b)]

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 provisions of the care set out in the plan of care are documented,
and to ensure that residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

Issued on this 4th day of November, 2016

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

Original report signed by the inspector.