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 1, 2022	2022_932442_0002	021177-21	Critical Incident System

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 Aylmer Long Term Care Residence
465 Talbot Street West Aylmer ON N5H 1K8

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

STEPHANIE MORRISON (721442)

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 25-28, 2022.

The following intake was completed in this Critical Incident System (CIS) inspection:
Log #021177-21 (CIS #2740-000024-21) was related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the the Administrator, Director of Care (DOC), Infection Prevention and Control (IPAC) Lead, Registered Practical Nurses (RPNs), a Rehab Assistant, Personal Support Workers (PSWs), a Housekeeper, and residents.

During the course of the inspection, the inspector(s) observed resident and staff interactions, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

Inspector Kim Byberg #729 was also present during this inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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. (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 has failed to ensure that a resident was reassessed, and the plan of care was reviewed and revised when the resident's care needs changed after a fall with injury.

A resident's transfer status and falls prevention strategies were not reassessed after a fall-related injury. The resident's transfer status had changed, but their plan of care had not been updated to reflect the change.

The resident not having their transfer status or falls prevention strategies reassessed, and not having their plan of care reviewed or revised after a fall with injury placed the resident at an increased risk of not having their care needs met and future falls.

Sources: observations of residents and staff-to-resident interactions; review of resident clinical records, and the home's falls prevention policy; and interviews with the DOC, and other nursing staff. [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 a resident is 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 change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that no person had administered a drug to a resident in the home unless that person was a physician, dentist, registered nurse, or registered practical nurse.

It was observed that a registered staff member gave medication to a person who was not a physician, dentist, registered nurse, or registered practical nurse to then administer to a resident. Another registered staff member stated that they have given medication to a person who was not a physician, dentist, registered nurse, or registered practical nurse to administer to a resident in the past. The home's policy on medication administration stated that only registered staff, physicians, and dentists may administer medications to residents.

A resident having received medication that was not administered by a physician, dentist, registered nurse, or registered practical nurse placed the resident at increased risk for a medication related adverse event.

Sources: observations of medication administration; review of the home's medication administration policy, and resident clinical records; and interviews with nursing staff. [s. 131. (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 no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program by not having offered or completed resident hand hygiene prior to having served multiple residents a meal or snack.

It was observed that staff had not offered or completed resident hand hygiene prior having served multiple residents a meal or snack. Two staff members admitted that they had not been offering or completing resident hand hygiene prior to having served meals or snacks. The IPAC Lead and the home's Public Health contact confirmed that the staff should have offered or completed resident hand hygiene prior to having served meals or snacks.

The staff not having offered or completed resident hand hygiene prior to having served multiple residents a meal or snack increased the risk of contamination of infectious disease.

Sources: observations of lunch and snack service; review of the Just Clean Your Hands Implementation Guide; and interviews with the IPAC Lead, the home's Public Health contact, and other staff. [s. 229. (4)]

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 all staff participate in the implementation of the infection prevention and control (IPAC) program by offering or completing resident hand hygiene prior to serving a meal or snack, to be implemented voluntarily.

Issued on this 2nd day of February, 2022

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

Original report signed by the inspector.