Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District
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Original Public Report

Report Issue Date: August 18, 2023	
Inspection Number: 2023-1234-0002	
Inspection Type: Critical Incident System	
Licensee: Chartwell Master Care LP	
Long Term Care Home and City: Chartwell Aylmer Long Term Care Residence, Aylmer	
Lead Inspector Christie Birch (740898)	**Inspector Digital Signature** Christie Birch Digitally signed by Christie Birch Date: 2023.08.18 08:22:25 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 14, 15, 16, 2023.

The following intake(s) were completed during this inspection:

- Intake: #00018338 -[CI 2740-000002-23] Fall of resident resulting in injury.
- Intake: #00021813 -[CI 2740-000005-23] Alleged abuse of a resident.
- Intake: #00091166 -[CI 2740-000016-23] Fall of resident resulting in injury.
- Intake: #00091300 -[CI 2740-000017-23] Fall of resident resulting in injury.

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Licensee must investigate, respond and act.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

The licensee failed to ensure that the alleged abuse of a resident was immediately investigated.

Rationale and Summary

The home submitted a critical incident (CI), related to alleged abuse to a resident.
The resident was observed by staff to have an injury. The resident stated that they had incurred the injury by someone. The staff who observed the injury and the report from the resident, stated that they did not report the injury or begin an investigation immediately.
Investigation notes also indicated that the investigation did not begin immediately when was first reported by the resident.

Sources: Interviews with staff; record review of progress notes in Point Click Care; investigation notes and CI. [740898]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to ensure that an allegation of abuse of a resident that resulted in harm or risk of harm to the resident was immediately reported to the Director.

Rationale and Summary

The home submitted a critical incident (CI) related to alleged abuse to a resident.
A resident was observed by staff to have an injury. The resident stated that they had incurred the injury by someone.
During an interview, the staff who observed the injury and the report from the resident, stated that they did not report the injury. The CI was reported to the Director four days after the resident reported it.

Sources: Interviews with staff and management; record review of progress notes in Point Click Care; investigation notes and CI. [740898]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee failed to ensure that a resident who exhibited altered skin integrity received 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.

Rationale and Summary

A resident was observed by staff to have an injury. During an interview, the registered staff member stated that they did not complete a skin assessment at that time.
During an interview with that registered staff and the resident care consultant, they confirmed that the expectation would have been a completed skin assessment, when this injury to the resident was observed.
The home's policy, Wound Care Treatment, last revised June 2023, stated "Residents with altered skin integrity will have a comprehensive assessment of their skin and wound care needs performed by a Registered Staff member."
In review of the Point Click Care (PCC) records and paper file of this resident, no skin assessment was completed on the date the injury was observed.

Sources: Interview with staff and resident care consultant; review of Critical Incident; PCC progress notes, careplan, assessments; Policy, Wound Care Treatment, last revised June 2023
[740898]