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 prévue 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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Apr 11, 2019	2019_704682_0009	009155-18, 024211-18, 032625-18, 002015-19	Complaint

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 Niagara Long Term Care Residence
120 Wellington Street P.O. Box 985 NIAGARA-ON-THE-LAKE ON L0S 1J0

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

AILEEN GRABA (682), LISA BOS (683)

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): March 18, 19, 20, 21, 25, 26, 27, 2019.

The following Complaint inspection(s) were conducted :
009155-18 related to prevention of abuse and neglect, personal support services
024211-18 related to nutrition and hydration, personal support services
032625-18 related to falls prevention, sufficient staffing
002015-19 related to sufficient staffing, personal support services

The following Critical Incident System inspection was conducted concurrently with this Complaint inspection:
028944-17 related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Care (DOC); Assistant Director of Care (ADOC); Food Service Nutrition Manager (FSNM); dietary aid(s), registered staff; personal support workers (PSW); residents and families.

During the course of this inspection, the inspector(s) observed the provision of the care and reviewed clinical health records, investigation notes, daily assignment sheets, overtime logs, staffing schedules, meeting minutes, policy and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Food Quality
Hospitalization and Change in Condition
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
0 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. (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 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. 2007, c. 8, s. 6 (2).

A complaint was submitted to the Director related to staffing. A clinical record review included a progress note that indicated resident #004 was not satisfied with care provided by personal support worker (PSW) #111 on an identified date. Further record review of point of care (POC) documentation included PSW #111 signature associated with tasks for resident #004 on 11 occasions after the incident on an identified date.

During an interview, resident #004 informed Inspector #682 that PSW #111 continued to provide care to them. Resident #004 became emotional when describing the incident. Resident #004 stated that they informed RPN #104 that they no longer wanted PSW #111 as a care provider. During an interview, PSW #111 stated that they only assist resident #004 when they have a staffing shortage. PSW #111 also stated that they no longer provide care for resident #004 as requested by the resident at the time of incident. During an interview, RPN #104 identified PSW #111 continued to care for resident #004 on the shifts when there was a staffing shortage. RPN #104 also stated that resident's #004 plan of care was not based on their preferences. During an interview, the Director of Care (DOC) stated that they were not aware PSW #111 continued to be involved with resident's #004 care. The home did not ensure that the care set out in resident's #004 plan of care was based on their preferences.

B) A complaint was submitted to the Director related to inadequate staffing, nursing and personal support services and falls prevention. A review of a schedule directed PSW staff that resident's #005, #006, #007, #008 were scheduled on identified dates for an intervention on an identified shift. A clinical record review of resident's #005 careplan, indicated resident #005 required assistance with personal care. A review of resident's #006 careplan, indicated that resident #006 required assistance with personal care. A review of resident's #007 care plan, indicated that resident #007 required assistance with

personal care. A review of resident's #008 care plan, indicated that resident #008 required assistance with personal care. A review of the daily staff assignment sheets on an identified date, indicated that four PSW were not scheduled and openings were not filled between 0600 hours and 1430 hours which is equivalent to 30 PSW hours for the entire home.
During an interview, the DOC stated that there were 124 residents residing in the long term care home and that there were 14 PSW vacancies in the home. During an interview, PSW #103 and PSW #108 both stated that on an identified date, resident's #005, #006, #007 and #008 did not get their preference of shower as scheduled but were provided a bed bath. PSW #108 acknowledged that each resident's plan of care indicated that a shower was scheduled for an identified shift. PSW #103 and PSW #108 stated that the showers that were not provided on an identified date to resident's #005, #006, #007 and #008, were not made up the following shift or day. The home did not ensure that the care set out in resident's #005, #006, #007, #008 plan of care related to bathing was based on their preference. [s. 6. (2)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.
Section 8 (1) of the Act, outlines the requirement for nursing and personal support services, including but not limited to, an organized program of personal support services for the home to meet the assessed needs of the residents.

A record review included the licensee's policy and procedures (effective February 2017), titled; 200- CLINICAL AND RESIDENT CARE, Shower; which included bathing as PSW tasks and directed PSW staff to "document care provided on the daily flow sheet or on the Point of Care (POC) terminal. "

The bathing schedule for resident #012 identified that they were bathed on identified days. Review of the POC documentation identified that bathing was not documented on identified dates, the residents scheduled bathing days.

The bathing schedule for resident #013 identified that they were bathed on identified days. Review of the POC documentation identified that bathing was not documented on identified dates, the residents scheduled bathing days.

The bathing schedule for resident #005 identified that they were bathed on identified days. Review of the POC documentation identified that bathing was not documented on identified dates, the residents scheduled bathing days.

The bathing schedule for resident #007 identified that they were bathed on identified days. Review of the POC documentation identified that bathing was not documented on identified dates, the residents scheduled bathing days.

During an interview, the Assistant Director of Care (ADOC) stated that it is their expectation that staff sign tasks completed on POC including baths/showers. The ADOC also stated that the bath/showers had been completed on the identified dates for residents #013, #005, #007 and #012 but were not signed off as completed by staff. The home failed to ensure that any actions with respect to the residents including interventions were documented. [s. 30. (2)]

Issued on this 23rd day of April, 2019

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

Original report signed by the inspector.