Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

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

# 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**

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419, rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jul 17, 2019 | 2019_594746_0013 | 005953-18, 016348-18, 020747-18, 021932-18, 026069-18, 032581-18 | 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 Aurora Long Term Care Residence
32 Mill Street AURORA ON L4G 2R9

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

AMANDEEP BHELA (746), JADY NUGENT (734), SHIHANA RUMZI (604)

## 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): June 13, 14, 17, 18, 19, 20, and 21, 2019.**

**Log # 021932-18 related to plan of care, housekeeping, personal care, infection prevention and control, transferring and positioning techniques, prevention of abuse and neglect and nutrition care and hydration programs.**
**Log # 026069-18 related to responsive behaviours and altercations and other interactions between residents.**

**During the course of the inspection, the inspector conducted observations of resident care provision, reviewed the home's investigation notes, resident clinical health records, and relevant home policies and procedures.**

**During the course of the inspection, the inspector(s) spoke with the Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Housekeeper, Registered Dietitian (RD), Environmental Services Manager (ESM), Assistant Director of Care (ADOC), Director of Care (DOC), and the Executive Director (ED).**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Housekeeping**
**Dignity, Choice and Privacy**
**Falls Prevention**
**Infection Prevention and Control**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 O.Reg 79/10, s. 101. Dealing with complaints**

**Specifically failed to comply with the following:**

**s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:**
**2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a documented record was kept in the home which included the nature of each verbal complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action; time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant.

Two complaints were submitted to the Ministry of Long-Term Care (MOLTC) ACTIONline. The first complaint was on an identified date, indicating concerns surrounding personal care, housekeeping, nutrition care and hydration programs, infection prevention and control program, transferring and positioning techniques, and prevention of abuse and neglect. The second complaint was on an identified date, related to responsive behaviours.

A record review for resident #027 indicated that an identified injury was discovered on the resident's lower extremity on an identified date, and at an identified time. On an identified time, the resident's substitute decision maker (SDM) was notified of the discovery. Another progress note made on an identified date, at an identified time, reported the resident's medical appliance was found in the hallway outside of resident's room. At time of the incident the resident's identified extremity was assessed for an identified injury.

During an interview with Assistant Director of Care (ADOC) #119 they acknowledged that the SDM contacted the home via telephone to express their concerns on how the two

incidences could have happened. ADOC #119 confirmed that they did an investigation by speaking with staff and looking at documentation. They stated that in both incidences that they were unsure of the cause of the incident.

As part of the inspection Inspector #734 reviewed the home's complaint log book for an identified period. There were no records of a verbal or written complaint being received by resident #027's SDM for either of those months. In addition, they did not have any written documentation to support what the home did to resolve the complaint other than a hand written statement by a staff member on an identified date.

Director of Care (DOC) #120 in an interview with Inspector #734 confirmed that the home did not have a record of the complaint received from resident #027's SDM, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, (if any), every date on which any response was provided to the complainant and a description of the response, and any response made in turn by the complainant. O. Reg. 79/10, s. 101. (1) 2. [s. 101. (1) 2.]

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**Issued on this 17th day of July, 2019**

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

**Original report signed by the inspector.**