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
Mar 2, 2020	2020_784762_0007	020448-19, 022986-19	Complaint

Licensee/Titulaire de permis

Chartwell Master Care LP
7070 Derrycrest Drive Suite 700 MISSISSAUGA ON L5W 0G5

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

MOSES NEELAM (762), ROMELA VILLASPIR (653)

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): February 4, 5, 6, 7, 10, 11, 12, 13, 14, 18 and 20, 2020

During this inspection the following complaint intakes were inspected:
- Intake log related care and services.
- Intake log related to continence care.

During the course of the inspection, the inspector(s) spoke with During the course of this inspection:
During the course of the inspection, the inspector(s) spoke with Residents, Substitute Decision Makers (SDM) the Executive Director (ED), Director of Care (DOC), Assistant Director of Cares (ADOC), Registered Dietitians (RD), Registered Nurses (RN), Registered Practice Nurses (RPN), Personal Support Workers (PSW), Foot Care Nurse (FCN), Behaviors Support Ontario Lead (BSO) and Nurse Practitioner (NP).

During the course of the inspection, the inspector made observations of staff and resident interactions, provision of care, conducted reviews of health records, home's critical incident logs, home's trust accounts, and relevant home policies and procedures.

PLEASE NOTE: A Written Notification and Voluntary Plan of Correction related to LTCHA 2007, c. 8, s. 6 (1) (c) was identified in this inspection and has been issued in Inspection Report #2020_832604_0002, dated March 2, 2020, which was conducted concurrently with this inspection.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Food Quality
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Responsive Behaviours
Trust Accounts

During the course of this inspection, Non-Compliances were issued.

- **3 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	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 O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the resident received preventative and basic foot

care service s, including the cutting of toenails, to ensure comfort and prevent infection.

1. The Ministry of Long-Term Care (MLTC) received a complaint regarding the provision of identified healthcare services. The complainant stated that the staff of the Long-Term Care Home (LTCH) notified them that an incident had occurred with resident #011. The complainant further questioned the type of identified healthcare services the resident #011 was receiving.

In an interview, complainant #100 indicated the staff of the LTCH called the complainant to notify them that an incident had occurred with resident #001's care. The complainant further stated that they had not received an update with regards to this incident from the LTCH and that they were not aware of the procedure in the LTCH with regards to identified healthcare services.

A record review was conducted, the LTCH policy on identified healthcare services and resident #011's finance file. The Care Plan indicated resident was to receive the identified healthcare services routinely every six weeks. Resident profile under PCC indicated they were to receive identified healthcare services every six weeks. Policy regarding the identified healthcare services with effective date February 2007, indicated that the assessment and all care provided must be documented in resident file, additionally, the care provider was to schedule their own visits and notify the SDM of any care concerns. Resident's finance file had a document by the title Long Term care home agreement for unfunded services, signed on the identified date by the SDM, indicated that the resident was to receive identified healthcare services every six weeks. Progress notes between the identified dates, indicated that the provision of identified healthcare services was only documented on two identified dates, and not every six weeks as per the long term care home agreement for unfunded services and the care plan. Additionally, the progress notes indicated the incident with the resident’s care had occurred on an identified date.

In an interview, FCN #111 stated they visited resident #011 every two weeks, however, due to resident behaviour, they were not able to provide identified healthcare services, and this was not documented on the resident file. FCN #111 indicated they notified various nurses regarding the resident’s behaviour during the identified period.

In separate interviews PSW #107, RN #113, RPN #114 and RPN #123 indicated that resident #011 was to be provided identified healthcare services by the identified care provider and that they had not provided identified healthcare services for this resident

during the identified period. They further indicated that FCN #111 did not communicate with them that the identified healthcare services was not provided due resident's behaviors.

In an interview, ADOC #135 reviewed the above plans of care, progress notes and resident profile, confirmed that the resident did not receive identified healthcare services during the identified period, as per the documentation. The resident did not receive preventative and basic care services as indicated.

2. Resident #017 was reviewed for the provision of identified healthcare services between the identified dates, related to a non compliance identified in resident #011's identified healthcare services. The resident sample size was expanded to include resident #017's identified healthcare services for the identified dates.

A record review was conducted between the identified dates, and resident #017's finance file. The Care Plan indicated resident was to receive identified health care services routinely by identified care provider every six weeks, this intervention was initiated on identified date. Resident's profile under PCC indicated they are to receive identified healthcare services every six weeks. Resident's finance file had a document by the title Long Term care home agreement for unfunded services, signed on identified date, indicated that the resident was to receive identified healthcare services every six weeks. Progress notes between the identified dates, indicated that the provision of identified healthcare services was only documented on identified date, and subsequently on identified date, and not every six weeks as per the long term care home agreement for unfunded services and the care plan.

In an interview FCN #111 indicated that they visited the resident #017 once a month, however, due to resident behaviours, they were not able to provide identified healthcare services, and this was not documented on the resident file. FCN #111 indicated that they visited the resident last on identified date, for which they did not document a late entry note. FCN #111 indicated they notified various nurses regarding the resident’s behaviour during the period. Furthermore, FCN #111 stated the nurse or the PSW's may have provided identified healthcare services to resident. However, there was no evidence of this in the documentation.

In separate interviews, PSW #107, RN #113, RPN #114 and RPN #123 indicated that FCN #111 did not communicate with them that identified healthcare service were not provided due resident's behaviours. In an interview, RPN # 123 indicated that they were

not aware of any alternative care that was provide if the identified healthcare service was not provided.

In an interview, ADOC #135, reviewed the above plans of care, progress notes and resident profile, confirmed that the resident did not receive identified healthcare services every six weeks during the identified period as per the documentation. Additionally, they stated that the provision of care for of the identified healthcare service was documented once in between the identified dates. The resident did not receive preventative and basic identified healthcare services.

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 each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection, to be implemented voluntarily.

WN #2: 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).

Findings/Faits saillants :

The licensee has failed to ensure that the provision of basic foot care services set out in the plan of care was documented.

Resident #018 was reviewed for the provision of identified healthcare services between the identified dates, related to a non compliance identified in resident #011's identified healthcare services. The resident sample size was expanded to include resident #018's identified healthcare services for the past year.

A record review was conducted between the identified dates, resident #018's finance file and the LTCH policy on foot care. The Care Plan indicated resident #018 was to receive identified healthcare services on identified days and as required, this intervention was initiated. Resident profile indicated they were to receive identified healthcare services every six weeks. Policy titled Identified healthcare services with effective date February 2007, indicated that the assessment and all care provided must be documented in resident file, additionally, the identified healthcare provider was to schedule their own visits and notify the SDM of any identified healthcare concerns. Resident finance file had a document by the title Long Term care home agreement for unfunded services, signed on identified date, by the SDM, indicated that the resident was to receive identified healthcare services every six weeks. Progress notes between the identified dates, indicated that the provision of foot care was only documented by the FCN#111 on identified dates, and not every six weeks as per the long term care home agreement for unfunded services.

During an interview, FCN #111 told the inspector that they visited the resident every six to eight weeks, the last visit was on identified date for which they did not document a note as of the identified date. Furthermore, FNC #111 stated the nurse or the PSW's may have provided identified healthcare services for resident #018.

In separate interviews, PSW #127 and RN #128 indicated identified healthcare services were provided for resident #018 on identified days as per the plan of care, however, this was not documented, as Point of Care (POC) does not have a location to document the provision of identified healthcare services.
In an interview, ADOC #135, who reviewed the above plans of care, progress notes and resident profile, confirmed that identified healthcare services were provided as per the plan of care, however, this was not documented, as POC does not have a location to document the provision of identified healthcare services. The provision of identified healthcare services set out in the plan of care was not documented.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

The licensee has failed to ensure that procedures are implemented for addressing incidents of lingering offensive odours.

The Ministry of Long-Term Care (MLTC) received a complaint with regards to resident #011's room housekeeping concerns.

In an interview, Substitute Decision Maker (SDM) #100 stated, resident #011's room had housekeeping concerns. The complainant stated that this had been an ongoing concern since the date of resident's admission, however, the state of room had improved as of late. Complainant requested the past three months be inspected with regards to time frame.

Inspector conducted observations on identified dates, with regards to the identified housekeeping concerns. Resident #011's room had the identified housekeeping concerns on multiple different occasions.

Inspector conducted a record review of the LTCH procedures with regards to the identified housekeeping concern with an effective date of February 2016. Policy procedures included for the PSW's to use the maintenance request system to document the identified housekeeping concern, if the source of the identified housekeeping concern cannot be found. Additionally, procedures for the housekeeping staff included the reporting the identified housekeeping concern to the ESM if the identified housekeeping concern reoccurs after thorough cleaning.

A review of records titled Maintenance work Orders between the identified dates, was conducted. No evidence of a maintenance request to address the identified housekeeping concerns was made during this period for resident #011's room.

In separate interviews, PSW#107 and housekeeping staff #112 indicated that the

identified housekeeping concerns had been present in resident#011's room with varying degrees of strength for over two to three months. Housekeeping Staff #112 stated that multiple different interventions were used. PSW #107 stated that multiple interventions have been tried by staff including notifying the housekeeper.

As per the policy, if the source of the identified housekeeping concern could not be found or is persistent, a maintenance request is to be made and a report is to be made to the Environmental Services Manager (ESM) by the PSW and housekeeping staff respectively. In an interview, housekeeping staff #112, indicated the ESM was notified months ago. In an interview, PSW #107 indicated the housekeeping staff and the registered staff were notified, however, a maintenance request was not made.

In an interview, Executive Director (ED) #116 reviewed the above policies and maintenance records and confirmed a maintenance request was not made for the identified housekeeping concerns and they were not made aware of the identified housekeeping concerns. The licensee has failed to ensure that procedures are implemented for addressing incidents of the identified housekeeping concerns.

Issued on this 3rd day of March, 2020

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

Original report signed by the inspector.