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
May 25, 2020	2020_832604_0007	003425-20	Complaint

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 Aurora Long Term Care Residence
32 Mill Street AURORA ON L4G 2R9

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

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): March 3, 6, 10, 11, 12, and 13, 2020.

During this inspection a complaint related to continence, plan of care, and housekeeping was inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Director of Care (ADOC), Physician, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Worker (PSW), Physiotherapy (PT) and Program and Support Services Manager (PSSM).

During the course of the inspection, the inspector conducted observations of staff to resident interaction, resident observation, reviews of resident health records, home's complaints for 2019 & 2020, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Personal Support Services
Recreation and Social Activities

During the course of this inspection, Non-Compliances were issued.
- **2 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. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the resident who was incontinent had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

The Ministry of Long-Term Care (MLTC) received a complaint indicating resident #001 had an identified diagnosis and was transferred to hospital. The complainant alleged the home's staff did not determine that the resident’s condition had changed, and care was not provided.

A review of resident #001’s documentation was carried out and it was noted after the resident was transferred to hospital the resident was discharged from the Long-Term Care home (LTCH) to the hospital as per families request. A review of resident #001’s plan of care consisted of identified focuses and interventions which were not individualized to resident #001’s identified needs.

In separate interviews, Personal Support Workers (PSW) #115, #116, #118, and #120, Registered Practical Nurse (RPN) #108, #114, #117, #121, #122, and #123, and Assistant Director of Care (ADOC) #102 indicated staff would refer to the resident’s care plan for directions related care needs. The staff and Inspector #604 reviewed resident #001’s plans of care during separate interviews and acknowledged the continence plan of care was not individualized to resident #001.

2. As areas of non-compliance was identified related to resident #001, the resident sample was expanded to resident #002 and #003.

A review of resident #002 and #003’s plan of care was carried out. It was noted the care plan did not consist of an identified focus or routine related to an identified care need for the residents.

In separate interviews, PSW #116, RPN #123, and ADOC #102 indicated staff would refer to the resident’s care plan for directions related to identified care. The staff and Inspector #604 reviewed resident #002 and #003’s plan of care during separate interviews and the staff acknowledged resident #002 and #003’s care plan was not individualized to the resident’s identified care needs.

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 the resident who was incontinent had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented, 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

The licensee has failed to ensure that the resident, the SDM, if any, and the designate of the resident/SDM had been provided an opportunity to participate fully in the development and implementation of the plan of care.

The Ministry of Long-Term Care (MLTC) received a complaint indicating when complainant #016 and family visited resident #001, they noted an identified piece of equipment in the residents room which the Substitute Decision Maker (SDM) was unaware of and stated when they observed care being provided and resident #001 appeared to be afraid.

A review of resident #001's progress notes was carried out for an identified period and Physiotherapist (PT) #104 had documented the resident's identified care need. A part of the documentation indicated resident #001 required identified equipment with two-person assistance at the time of assessment and the resident was cooperative with the assessment. Staff reported resident gets confused at times and may not follow directions during care. The PT further documented when the resident was confused care can be carried out with a different type of equipment with two-person assistance.

A review of resident #001's plan of care consisted of identified care needs.

In separate interviews, PT #104 and ADOC #102 stated a resident care needs would be communicated with the resident's SDM. The PT and ADOC stated resident #001's SDM #106 had asked the LTCH to communicate with them all care directives for the resident. The PT and ADOC acknowledged that the SDM of resident #001 had not been provided the opportunity to participate fully in the development and implementation of the plan of care as they where not informed of resident #001's identified care.

Issued on this 11th day of June, 2020

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

Original report signed by the inspector.