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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: June 12, 2023

Inspection Number: 2023-1139-0001

Inspection Type:
Complaint
Critical Incident System

Licensee: Chartwell Master Care LP, by its general partner, GP M Trust, by its sole truste

Long Term Care Home and City: Chartwell Aurora Long Term Care Residence, Aurora

Lead Inspector	**Inspector Digital Signature**
Eric Tang (529)	Eric Tang Digitally signed by Eric Tang Date: 2023.06.13 15:20:51 -04'00'

Additional Inspector(s)
Asal Fouladgar (751)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 17-19, 23-26, 29-31, 2023

The following intakes were completed in this complaint inspection:
· Two intakes were related to food, nutrition, and hydration, continence care, and resident care and support services; and
· An intake was related to responsive behaviors.

The following intakes were completed in this Critical Incident (CI) inspection:
· Two intakes were related to falls prevention and management
· Four intakes were related to prevention of abuse and neglect; and
· One intake was related to food, nutrition, and hydration, and resident care and support services.

The following intake was completed in this inspection:
· An intake was related to falls prevention and management.

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

Continence Care
Falls Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Resident Care and Support Services
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

1. The licensee failed to ensure that staff collaborated with each other in implementation of the resident's plan of care when they exhibited responsive behaviours.

Summary and Rationale

The Ministry of Long-Term Care (MLTC) received a Critical Incident Report (CIR) related to an allegation of physical abuse from a personal support worker (PSW) to the resident during care.

A review of the resident's records indicated the resident would exhibit responsive behavior due to their medical conditions. As per the resident's plan of care, interventions were available to better support the resident's condition.

During a care episode the resident had exhibited responsive behavior towards two direct care staff. The staff indicated that they then employed an intervention but were unsuccessful in managing the resident's responsive behavior. Staff continued with care despite the resident's response and confirmed they had not contacted a registered nursing staff to implement an alternate intervention suitable for the situation.

The Director of Care (DOC) asserted that the direct care staff were expected to communicate with the registered nursing staff when initial care interventions were not effective in managing the resident's response.

There was moderate risk to the safety and well-being of the resident when they did not receive all the required interventions in their plan of care related to their responsive behaviours.

Sources: CIR, the resident's clinical records, the home's investigation notes, and interviews with staff.
[751]

2. The licensee failed to ensure that staff collaborated with each other in implementation of a resident's plan of care when they exhibited responsive behaviours.

Summary and Rationale

The MLTC received a CIR related to an allegation of staff to resident emotional and verbal abuse during care.

The resident's records indicated they would exhibit responsive behavior due to their medical conditions and interventions were available to support the resident's condition as per their plan of care.

During a care episode the resident had demonstrated responsive behavior towards two direct care staff. The staff indicated that they then employed an intervention but were unsuccessful in managing the resident's responsive behavior. The staff continued with the care despite the resident's response and confirmed they had not contacted a registered nursing staff to implement an alternate intervention suitable for the situation.

The DOC further asserted that the staff failed to collaborate with the registered nursing staff to administer another intervention to address the resident's responsive behavior during care.

There was moderate risk to the safety and well-being of the resident when they did not receive all the required interventions in their plan of care related to their responsive behaviours.

Sources: CIR, the resident's clinical records, the home's investigation notes, and interviews with staff.
[751]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.

The license failed to ensure that the outcomes of the care set out in the plan of care for the resident was documented by registered nursing staff.

Summary and Rationale

The MLTC received a complaint related to resident care received at the long-term care (LTC) facility.

The home's "Documentation-General Guidelines" directed staff to "document as frequently as necessary in the multidisciplinary Progress Notes to reflect the resident's status and progress and the level of care provided".

The resident had experienced a change in health condition during one shift and was attended by a registered nursing staff. Initial assessment findings and actions taken were then documented in the resident's electronic health record. However, the staff indicated that they had completed subsequent assessments but findings were not documented in resident's record.

The resident's condition remained unstable on the following shift and was attended by another registered nursing staff. However, the staff admitted they had not fully documented their assessments and care provided in resident's record. The resident was later sent to a medical facility for treatment.

The DOC stated that according to the home's documentation policy which was based on the College of Nurses (CNO) Standards, registered staff were required to document any action taken related to assessment and re-assessment of the residents.

Failure to document pertinent information of nursing assessments, actions taken, and the resident's clinical status, could have caused potential risk of harm to the resident as the resident's condition was not fully communicated between staff, therefore impacting the resident's health status and plan of care.

Sources: Resident's clinical records, the home's documentation policy, last revised April 2017, and interviews with staff.
[751]

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee failed to ensure that staff used safe transferring device when assisted the resident after their fall.

Summary and Rationale

The home submitted a CIR to the MLTC related to a fall of the resident that resulted in a significant change in health condition.

A record review and an interview with a registered nursing staff indicated that the resident had experienced a fall and utilized a transferring technique to transfer the resident from the ground to a sitting surface. The resident was then later sent to a medical care facility for further treatment.

The home's fall prevention policy directed the staff to use another transfer technique when a resident had fallen unless the resident was able to stand with minimal assistance from staff.

The DOC asserted that staff were expected to adhere to utilizing the transfer technique as per the home's policy.

Failure to transfer the resident from the one surface to another without using a safe transferring device, increased the risk of further injury and pain to the resident.

Sources: CIR, the resident's clinical records, the home's fall prevention policy, and interviews with staff.
[751]

COMPLIANCE ORDER CO #001 Dining and Snack Service

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 8.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. The Registered Dietitian (RD), or a leadership team designate, to identify all residents at high risk for choking and requiring staff's supervision during mealtime.

2. The RD, or a leadership team designate, to deliver a one-time training to all Activation staff on the identified residents' care plan interventions to be implemented during mealtime.

3. Training contents and attendance records (containing the trainer's full name, staff's full name, and training date) are to be documented and made available to an inspector upon request.

Grounds

The licensee has failed to provide the resident with personal assistance required to safely eat as comfortably and independently as possible.

Summary and Rationale

A CIR and a complaint were received by the MLTC concerning an incident that occurred during a mealtime.

The resident was admitted to the home with identified health conditions that would impact resident's eating and swallowing ability. As such, the resident would require specific interventions to be implemented during mealtime in order to mitigate risks. The interventions were documented in the resident's electronic care plan and were to be utilized during mealtime.

An interview with the RD and food and nutrition manager (FNM) asserted that staff assigned to the resident during mealtime was expected to sit and supervise the resident during the entire meal, and to carry-out the interventions as documented. The RD further stated the assigned staff were not leave the resident alone when there was food in front of them.

The resident's clinical record indicated an activity aide (AA) was assigned to sit and supervise the resident during mealtime on the specified day. As per the AA's handwritten document the resident was offered an alternate meal as they refused the initial plate of food. The alternate plate was then brought to the resident. Shortly after consumption, the resident had a sudden change in condition and resulted in an incident.

Upon interviewing the AA, the staff confirmed the resident had initially refused the initial plate of food and brought an alternate choice to the resident at their table. The AA then temporary engaged in another task but returned to support the resident shortly after. It was noted that the resident had already consumed a portion of their meal by self. The resident then experienced a sudden change in health condition and resulted in an incident.

The critical incident resulted in a high severity and impact to the resident when the home had failed to implement the required care interventions during the identified dining service.

Sources: CIR, the resident's clinical records, the home's investigation notes, and interviews with staff.
[529]

This order must be complied with by July 3, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.