Ontario

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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 2, 2016	2016_216144_0010	033575-15	Complaint

Licensee/Titulaire de permis

S & R NURSING HOMES LTD.
265 NORTH FRONT STREET SUITE 200 SARNIA ON N7T 7X1

Long-Term Care Home/Foyer de soins de longue durée

AFTON PARK PLACE LONG TERM CARE COMMUNITY
1200 AFTON DRIVE SARNIA ON N7S 6L6

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

CAROLEE MILLINER (144)

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, 8, 9, 2016

The inspection was related to dining services, infection prevention and control program, plan of care and falls prevention.

During the course of the inspection, the Inspector reviewed the inquiry and intake log #033575-15, infoline report IL-41658-LO, critical incident log #028612-15, critical incident report #2827-000020-15 and one resident clinical record.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Assistant Manager Resident Care, two Registered Practical Nurses, one Personal Support Worker and one Dietary Aide.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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	Legendé 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the following rights of residents were fully respected and promoted:
Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

A) One resident was identified as requiring specific precautions during the provision of care. The physician prescribed medication and ordered a medical test.
B) A referral was made to an external service provider for the medical test.
C) On the ninth day after the medical test was ordered, the service provider had not attended the home to complete the test. Registered staff checked the referral form to the service provider on two occasions to ensure it had been faxed.
D) Eleven days after the referral to the service provider, the medical test was completed.
I) The Administrator and RPN staff #104 confirmed the registered staffs follow up to the referral was a review of the fax transmission and not a telephone call to the service provider.
J) The Administrator and AMRC, confirmed that the registered staff follow ups to the referral, should have been a telephone call and inquiry about the untimeliness of the company's service to the resident.
K) The Administrator further confirmed the home had not provided the resident with the necessary services consistent with their needs when the service provider was not contacted a second time to expidite their service to the resident.
L) The resident's rights was not respected due to the delay in receiving test ordered by the physician. [s. 3. (1) 4.]

2. The licensee has failed to ensure that the following rights of residents were fully respected and promoted:
Every resident had the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive the information immediately.

A) One resident was identified as requiring specific precautions during the provision of care. On the same date, the resident's Substitute Decision Maker (SDM) provided an RPN with an alternate telephone number and advised the number was where they(SDM) could be contacted over the next few days if there were any concerns or an emergency. The telephone number provided to the nurse was documented in the progress note section of the resident's clinical record.
B) The resident's progress notes revealed on the same date, a Registered Nurse (RN) telephoned the SDM's home and left a voice mail asking the SDM to contact the home immediately as the resident's status had changed and if the resident could not be stablized, they would need consent to transfer them to hospital.
C) The Administrator, staff #100 and the AMRC, staff #102 both confirmed the resident's SDM's directive to nursing personnel for contact purposes was not followed, the RN left a voice mail on the SDM's land line and, the SDM did not receive the telephone voice mail on the evening it was left.
D) The Administrator further confirmed the resident's rights were not respected when the person designated to immediately receive information concerning any hospitalization, was not contacted. [s. 3. (1) 16.]

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 every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive the information immediately and, that every resident is cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any policy, protocol or procedure instituted or otherwise put in place was complied with.

A) The home's Oxygen Care Policy, last reviewed January 2014, provided the following direction to registered staff on the procedure for initiating oxygen therapy for a resident:

" During business hours, the Registered Team Member will notify the company that provides oxygen therapy. The fax sheet provided with all concentrators can be faxed directly to the company to advise them that oxygen therapy has been initiated."
"The company that provides oxygen therapy will visit the resident and complete an assessment of the resident's respiratory status."

B) The clinical record for one resident confirmed oxygen therapy was initiated using a portable oxygen tank.
C) One RPN, the Administrator and AMRC verified a referral was not faxed to the oxygen service provider to notify them of the need to assess the resident. The Administrator confirmed she contacted the oxygen service provider by telephone and was advised a fax transmission had not been received for the identified resident.
D) The Administrator and AMRC confirmed that the oxygen concentrator should have been used with the implementation of oxygen therapy for the resident not, a portable oxygen tank.
D) The Administrator and AMRC also confirmed that the home's oxygen policy was not followed when the service provider was not notified that oxygen therapy had been initiated for the resident and that due to the absence of notification, the resident was not assessed by a Respiratory Therapist during their illness. [s. 8. (1)]

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 any policy, protocol or procedure instituted or otherwise put in place is complied with, to be implemented voluntarily.

Issued on this 3rd day of March, 2016

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

Original report signed by the inspector.