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
Jan 16, 2020	2020_648741_0001	024384-19	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

AYESHA SARATHY (741), TERRI DALY (115)

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): January 2, 3, 6 and 7, 2020

The following Complaint was inspected as a part of this inspection:

IL-73263-LO / Log #024384-19 related to Hospitalization and Change in Condition

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), a Registered Nurse (RN), the Assistant Manager of Resident Care (AMRC), the Manager of Resident Care (MRC), the Administrator and a resident.

The Inspectors also observed residents, relevant policies and procedures and reviewed clinical records for identified residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Pain
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 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 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 the care set out in the plan of care was documented.

An anonymous complaint was received by the Ministry of Long-Term Care (MOLTC), in relation to concerns with the care provided to a resident by a staff member when the resident experienced a change in their condition on an identified date and was sent to the hospital.

The resident's progress notes were reviewed in Point Click Care (PCC) in relation to the incident and it was found that there were no progress notes documented for 18.5 hours prior to the resident being sent to the hospital.

The resident's Point of Care (POC) tasks were also reviewed for the shift before they were sent to the hospital. Fifteen POC tasks were required to be completed and documented on by Personal Support Workers (PSWs) for the identified resident during the shift. The review identified that no documentation had been completed for any of the 15 POC tasks by PSW staff.

During separate interviews with the PSW staff members who worked during that shift, they indicated that they were working short that day and did not document on care provided to the identified resident during their shift.

In an interview with the Manager of Resident Care (MRC), they said that staff were expected to document the provision of care even when working short and that staff should have done so.

The licensee failed to ensure that the provision of the care set out in the identified resident's plan of care was documented.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

The licensee has failed to ensure that a resident received individualized personal care, including hygiene care and grooming on a daily basis.

During an observation, the identified resident was found sitting in a lounge area. They were found not to be properly groomed and had poor hygiene.

This was reported to a Registered Practical Nurse (RPN), the inspector also questioned when the resident was last bathed, and the RPN responded that sometimes the resident refused their bath and would demonstrate behaviours. A review of the Point of Care (POC) documentation with the RPN showed that the resident had refused their last bath two days prior.

During an interview with a Personal Support Worker (PSW), they indicated that the resident could become aggressive during their bath and that would be indicated in the POC behaviour records on the same date the bath was refused.

During an interview with the Manager of Resident Care (MRC) they reviewed the clinical records related to the bath refusal and indicated that a refusal would be followed up with documentation under behaviours in POC and also documentation in the resident's progress notes. Documentation was not found in either of these places.

A second observation of the same resident was conducted after 1.5 hours and they were found to be in the same state of hygiene as they previously were observed to be in.

The MRC was on the resident home area at the time of the second observation and informed the Inspector that the resident was re-scheduled for a bath that evening.

A review of resident’s current care plan noted a hygiene goal that the resident would be neat, clean and odour free.

The MRC acknowledged that the identified resident should have received individualized personal care, including hygiene care and grooming on a daily basis ensuring the resident would be neat and clean. The MRC also acknowledged that staff should be recording the bath refusal in POC supported with a detailed progress note about resident behaviours and the teams action plan related to this.

WN #3: 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:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).
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).
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

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3. A response shall be made to the person who made the complaint, indicating,

i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) 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; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to 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 was dealt with as follows:
The complaint was investigated and resolved where possible and where the complaint alleged harm or risk of harm to one or more residents, the investigation was commenced immediately.

An anonymous complaint was received by the Ministry of Long-Term Care (MOLTC) in relation to concerns with the care provided to a resident by a staff member when the resident experienced a change in their condition on an identified date and was sent to the hospital. The complainant stated that they brought their concern forward to the home and nothing was done.

In an interview with the Manager of Resident Care (MRC), they stated that a staff member came to them on an identified date with concerns related to the care provided to a resident by another staff member. They said that another staff member came to them on a different date with concerns related to the care provided to a different resident by the same staff member. They said that they did not initiate an investigation upon receipt of the first complaint they received and had not yet initiated an investigation for the second complaint they received.

The licensee failed to ensure that the verbal complaints made to the licensee concerning the care of residents were investigated and resolved where possible.

2. The licensee has failed to 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 was dealt with as follows:
A response was made to the person who made the complaint, indicating,
i. what the licensee had done to resolve the complaint, or
ii. that the licensee believed the complaint to be unfounded and the reasons for the belief.

Further to the interview with the Manager of Resident Care (MRC), they were asked whether they had followed up with the two complainants regarding their complaints and they said they had not and should have.

The licensee failed to provide a response to the two complainants within 10 business days of the receipt of the complaint, indicating what the licensee had done to resolve the complaint, or that the licensee believed the complaint to be unfounded and the reasons for the belief.

3. The licensee has failed to ensure that a documented record was kept in the home that included,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) 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;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the
response; and
(f) any response made in turn by the complainant

The home’s Complaint log called "2019 Concern/Complaint/QI” was reviewed and there was no documented evidence of the two complaints that had been lodged with the Manager of Resident Care (MRC).

The MRC was asked about the home's procedure for dealing with complaints in an interview. They said that when a verbal or written complaint is received by the home a feedback form called 'Admin 08-09 Customer and Team Member Internal Feedback Process' is completed and an investigation initiated. They acknowledged that the complaints made by the two staff members were not documented using the "Admin 08-09 Customer and Team Member Internal Feedback Process" form and should have been.

The licensee failed to ensure that a documented record was kept in the home that included the complaints that were received by the home on two identified dates, in relation to care concerns for two different residents.

Issued on this 16th day of January, 2020

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

Original report signed by the inspector.