Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Dates of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
December 7-10, 2010	2010_188_9503_08Dec080525	Complaint Log #: S-00284, IL-14473-SU Log #: S-00290, IL-14498-SU

Licensee/Titulaire
Board of Management of the District of Parry Sound West, 21 Belvedere Avenue, Parry Sound, ON P2A 2A2, Fax: 705-774-7300

Long-Term Care Home/Foyer de soins de longue durée
Belvedere Heights, Belvedere Avenue, Parry Sound, ON, P2A 2A2, Fax: 705-774-7300

Name of Inspectors/Nom de l'inspecteurs
Margot Burns-Prouty #106
Melissa Chisholm #188
Gail Peplinskie #154

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection.

During the course of the inspection, the inspectors spoke with: the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Food Service Manager, the Education Coordinator, Registered Nursing staff, Personal Support Workers (PSW), residents involved in the complaint, various residents currently residing in the home.

During the course of the inspection, the inspectors: Conducted a walk-through of all resident home areas and various common areas, observed the care of residents named in the complaint, observed dinning room service and reviewed the following:

- Policies and procedures related to prevention of abuse and neglect
- Training schedules, in-service records and content of educational sessions
- Health care records of residents named in the complaint
- Minutes of some staff meetings

The following Inspection Protocols were used during this inspection:
Dining Observation
Responsive Behaviours
Prevention of Abuse, Neglect and Retaliation
Training and Orientation

Findings of Non-Compliance were found during this inspection. The following action was taken:

8 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.3(1)1 Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Findings:

1. The inspector observed a resident who had removed their clothing exposing the resident. Several residents sitting near the resident and a staff member were present. The resident sat exposed for 6 minutes without staff intervening. The licensee did not ensure that the resident was treated in a way that respected the resident's dignity.

2. The inspector walked into a resident's room after knocking on the open door. The resident sat exposed to the inspector from the waist down while sitting on the side of the bed. The resident's roommate was in the room and witnessed the resident's care being provided. The licensee did not ensure that the resident was treated in a way that respected the resident's dignity.

Inspector ID #:	154

WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.3(1)8 Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted: 8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

Findings:

1. The inspector observed an RPN administer insulin to a resident during breakfast service, in the dinning room. The RPN lifted the bottom edge of the resident's long-sleeve shirt to administer the insulin to the arm. The resident was sitting at the table with 2 other residents. The licensee did not ensure that the resident's right to privacy in treatment was respected.

2. The inspector observed RPN administer insulin to a resident during breakfast service, in the dinning room. The RPN lifted the bottom edge of the resident's long-sleeve shirt to administer the insulin to the arm. The resident was sitting at the table with 3 other residents. The licensee did not ensure that the resident's right to privacy in treatment was respected.

Inspector ID #:	188

WN #3: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6(1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, c) clear directions to staff and others who provide direct care to the resident.

Findings:

1. Inspector observed a resident alone in a common room with the door closed instead of in the dinning room during the breakfast meal service. The plan of care for the resident does not identify removing the resident from the dining room. The licensee has failed to ensure that there is a written plan of care for the resident sets out clear direction to staff and others who provide direct care to the resident.

2. A review of a resident's progress notes indicates documented responsive behaviours. The written plan of care for the resident does not include clear direction to staff and others who provide direct care related to dealing with these responsive behaviours. The licensee has failed to ensure that there is a written plan of care for the resident which sets out clear direction to staff and others who provide direct care to the resident.

Inspector ID #:	188

WN #4: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6(7) Every licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Findings:

1. Inspector observed a resident in the dining room for breakfast. The plan of care for the resident identifies the resident requires staff assistance. The resident was not provided assistance throughout the meal. The licensee did not ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

2. Plan of care for a resident indicates food is to be kept in the fridge for the resident. No food was located in the fridge for this resident. The licensee did not ensure that care set out in the plan of care is provided to the resident as specified in the plan.

3. The plan of care for a resident identifies to remove the resident from the area if they become agitated. Inspector observed the resident who had become agitated but was not removed from the area. The licensee did not ensure that care set out in the plan of care is provided to the resident as specified in the plan.

Inspector ID #:	154, 106, 188

WN #5: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.76(4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

Findings:

1. Inspector 188 reviewed homes education/in-servicing records for 2010. Annual retraining for the home's policy on the prevention of abuse and neglect occurs at a full-day education session held by the Education Coordinator. Inspector determined that 24 staff of the approximate 135 staff employed had attended a full day education session in 2010. This does not meet the requirement that all staff have annual retraining related to the homes prevention of abuse and neglect policy.

2. It was reported to inspector 154 by 2 of 3 PSWs interviewed that they have not had any retraining relating to prevention of abuse and neglect in 2010. This does not meet the requirement that all staff have annual retraining related to the homes prevention of abuse and neglect policy.

Inspector ID #:	188, 154

WN #6: The Licensee has failed to comply with O.Reg. 79/10, s.53(1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours: 2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.

Findings:

1. It was reported to the inspector that a resident has responsive behaviours in relation to continence care. The inspector reviewed the progress notes and the behaviours have been documented. This behaviour is not identified in the residents' plan of care. Written techniques and interventions, to prevent, minimize or respond to the resident's responsive behaviours were not developed to meet the resident's needs.

2. Inspector reviewed progress notes for a resident which identified a responsive behaviour related to refusal of care. This behaviour is not identified in the resident's plan of care. The licensee did not ensure that written strategies, including techniques and interventions, to prevent, minimize or respond to the resident's responsive behaviours were developed to meet the resident's needs.

Inspector ID #:	106, 188

WN #7: The Licensee has failed to comply with O.Reg. 79/10, s.72(3)a The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, preserve taste, nutritive value, appearance and food quality

Findings:

1. December 8, 2010 at 1145 inspector 106 discovered, in the resident refrigerator on the Oak Ridge Unit, the following:
    - A container of food labeled with a resident's name that contained spoiled soup or a similar food type substance
    - A covered serving platter with its lid ajar with cheese cubes that were discoloured and appeared hard
    - A cream based dip in a separate container on the platter that was open and visibly dry in spots

   No date was located on any of the food containers. The licensee failed to ensure all food and fluids in the food production system are prepared, stored, and served using methods to, preserve taste, nutritive value, appearance and food quality.

Inspector ID #:	106

WN #8: The Licensee has failed to comply with O.Reg. 79/10, s.73(2)b The licensee shall ensure that, no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

Findings:

1. Inspector observed during the meal service that food was placed on the table in front of two residents. Both residents require staff assistance to eat. No staff member was available to feed the residents and the meals sat untouched for several minutes until a staff member was available to start assisting them. The licensee did not ensure that residents who required assistance with eating or drinking where severed a meal only when someone was available to provide the assistance required by the resident.

2. Inspector observed during the meal service that food was placed on the table in front of a resident. The resident requires staff assistance to eat. No staff member was available to assist the resident and the meal sat untouched for several minutes until a staff member was available to start assisting the resident. The licensee did not ensure that a resident who require assistance with eating or drinking where severed a meal only when someone was available to provide the assistance required by the resident.	
Inspector ID #:	106, 154

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). January 20, 2011