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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Jul 6, 2016	2016_397607_0015	012403-16/035031-15	Critical Incident System

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

BON AIR RESIDENCE
131 Laidlaw Street South Cannington ON L0E 1E0

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

JULIET MANDERSON-GRAY (607)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 28 and 29, 2016.

During this Critical Incident Inspection, the following intakes were reviewed and inspected upon #035031-15 and 012403-16.

Summary of the Intakes:

1) #035031-15 - regarding improper incompetent care resulting a resident choking.

2) #012403-16 - regarding staff to resident alleged abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (Admin/DOC), a Dietitian, a Registered Nurse, (RN), a Registered Practical Nurse (RPN), Personal Support Workers (PSW), a Cook and a Substitute Decision Maker (SDM).

During the course of this inspection the inspector reviewed clinical health records, observed staff to resident interactions, observed dining and snack services, reviewed home's investigations notes (specific to identified Critical Incident Reports), reviewed home specific polices related to Risk Management -Resident Abuse Prevention, Food and Nutrition Services, reviewed staff training records and resident's dietary profiles.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Dining Observation
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the resident's needs and preferences specifically related to resident #001.

Related to Log # 012403-16:

The home submitted a Critical Incident Report (CIR) on an identified date for an incident related to staff to resident alleged abuse. The Critical Incident identified the following:

Resident #001 requested continence care and was told by PSW #104, "he/she would only assist him/her with this care, if the resident would stay up in his/her chair until dinner time." The resident stated that "he/she was in pain and wished to lie back down, after receiving his/her care." The staff left the room and did not provided the care to the resident.

A review of the plan of care for resident #001 indicated the resident uses a transfer device and requires two to three staffs assistance for continence care.

An interview with PSW #104 confirmed that he/she did not provide the care the resident requested and that the plan of care was not followed.

An interview with the Administrator/DOC confirmed that PSW #104 did not follow the resident's plan of care.

Therefore, the licensee has failed to ensure that the care set out in the plan of care was based on an assessment of resident #001's needs and preferences. [s. 6. (2)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan

Related to Log # 035031-15:

A Critical Incident Report (CIR) was received from the home indicating that on an identified date, resident #002 aspirated because he/she was given the incorrect diet.

A review of the plan of care and the weekly menu with a title of "Week Two, Saturday confirmed the resident's diet at the time of the incident.

Interview with PSW #101 and RN #100 confirmed resident #002's diet and indicated that he/she had received the incorrect diet on the date the incident occurred. PSW #101 further indicated that the cook had stepped away from the servery, when RPN #103 provided the resident with regular textured meat without verifying the resident's diet.

Interview with the Dietitian indicated that the diet served on the date of the incident to resident #002 was regular textured meat and it would not have been appropriate for the resident.

Interview with the Administrator/DOC confirmed that RPN #103 failed to follow the dietary profile for resident #002, and the expectations is that staffs are required to ask for diet by resident's name. The Administrator/DOC further indicated that the resident was given incorrect textured meat the date the incident occured.

Therefore, on an identified date the licensee failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan, as resident #002 aspirated on regular textured meat. [s. 6. (7)]

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 ensure that the care set out in the plan of care was based on an assessment of resident #001's needs and preferences.
will ensure that the care set out in the plan of care to be provided to resident #002 as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with, specifically related to resident #001.

Related to Log # 012403-16:

The home submitted a Critical Incident Report (CIR) on an identified date for an incident related to staff to resident alleged abuse. The Critical Incident identified the following:

Resident #001 requested continence care and was told by PSW #104, "he/she would only assist him/her with this care, if the resident would stay up in his/her chair until dinner time." The resident stated that "he/she was in pain and wished to lie back down, after receiving his/her care." The staff left the room and did not provided the care to the resident.

A review of the home's investigations notes revealed that the incident occurred on an identified date and the CIR was not submitted to the Director until three days later.

A review of the home's Risk management, Resident Abuse-Abuse Prevention policy # LTC-CA-ALL-100-05-02 with an identified date directs:

Policy (page 5 of 18):

Abuse reporting is mandatory: All staff members are required to report any abuse, suspected abuse or allegations of abuse immediately to the respective supervisor, failure to report abuse of any kind is subjected to disciplinary action.

Interview with the Administrator/DOC confirmed that PSW #107 did not notify anyone of the above identified incident related to resident #001 until three days after the incident occurred and the expectations is that alleged or suspected abuse be reported immediately to the registered staff or herself.

Therefore, the home did not follow its Risk management, Resident Abuse-Abuse Prevention policy # LTC-CA-ALL-100-05-02 for resident #001 by not reporting an alleged or suspected abuse immediately to the Director. [s. 20. (1)]

Issued on this 6th day of July, 2016

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

Original report signed by the inspector.