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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 31, 2014	2014_291552_0028	O-001030-14	Resident Quality Inspection

Licensee/Titulaire de permis

SPECIALTY CARE CASE MANOR INC.
400 Applewood Crescent, Suite 110, VAUGHAN, ON, L4K-0C3

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

Case Manor
28 BOYD STREET, P.O. BOX 670, BOBCAYGEON, ON, K0M-1A0

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

MARIA FRANCIS-ALLEN (552), GWEN COLES (555), WENDY PATTERSON (556)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 14, 15, 16, 17, 20, 21, 22 and 23, 2014

The following Critical Incident inspection was also completed currently during this RQI (log # 1007-14)

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Assistant Director of Care (ADOC),the Director of Programs and Admission, the Environmental Service Manager, Registered Dietitian (RD), Program Manager, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSW), Family Council President, Resident Council President, family members and Residents.

During the course of the inspection, the inspector(s) toured the home, observed dining services,observed administration of medication, reviewed resident health records, reviewed the home's investigation reports and the home's policies (Disease Protocols, Fall Prevention and Management, Pain and Symptom, Complaints, Skin and Wound, Infections Control and Prevention and Medication Administration).

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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 O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimeters. On October 14, 2014 at 10:45 during the Initial Tour of the home it was observed that a window on the third floor Dining Room opened greater than 15 centimeters. The window overlooked a balcony which had a concrete floor and contained chairs and tables, allowing for potential egress and falls risk.Residents were noted to be in close proximity of this window. The Executive Director (ED) was notified and the window was observed at 14:00 to be unable to be opened greater than 15 centimeters. On October 16, 2014 Inspector #552 noted during observation of Resident # 018's room that the window could be opened greater than 15 centimeters. This was also immediately reported to the Executive Director. The resident's room overlooks the parking lot which is a potential falls risk. It was reported by the Executive Director at 13:00 that window had been secured and observed on October 17, 2014 to be unable to be opened greater than 15 centimeters.

On October 16, 2014 the ED and Maintenance Manager reported that all windows in home have been checked, can open less than 15 centimeters and a label has been attached advising staff, family and visitors to seek assistance when opening windows. On October 17, 2014 the ED and Maintenance Manager reported all windows in building are going to have 2 brackets installed in the frame to ensure that the windows are unable to be opened greater than 15 centimeters.[s. 16.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Resident # 009 was admitted to the home on an identified date and at the time of the admission had one pressure ulcer. The resident's plan of care indicated weekly skin assessments should be completed and documented by the Registered Staff.
Review of the progress notes indicate that since the resident's admission, weekly skin assessments were being documented by Registered Staff until September 24, 2014 , after which there was no further documentation regarding weekly skin assessments. There was no evidence found to indicate that the frequency of the weekly skin assessments have changed.
Interview with Staff # 110 confirmed that she had been conducting weekly assessments for the resident (after September 24, 2014) but did not complete the documentation. Both Staff # 108 and the ADOC confirmed that the weekly skin assessment should have been documented in the progress notes. [s. 30. (2)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a response in writing is provided within 10 days of receiving Resident's Council advice related to concerns or recommendations about the operation of the home.

Review of Resident Council Minutes dated April 28, 2014 identified issues related to sunlight shining in Dining Room door; water coming in under doors in balcony, fountain repair needed; and that residents on the third floor found the coffee too strong. Evidence was found of a written response from the ED to all issues except the need for the fountain to be repaired. The written response however was not dated. A verbal response from the ED related to fountain issue was noted in minutes.

Review of Resident Council Minutes dated June 26, 2014 identified issues related to residents being left out of activities and limited activities planned. There is no evidence of a written response from the licensee.

Interview conducted on October 16, 2014 with the Resident Council President reported the licensee attends when invited and provides a verbal response at the time of the meeting and has provided periodically a written response to issues related to the operation of the home. Interview was conducted on October 17, 2014 with the ED who reported that she attends the majority of Resident Council meetings but only when invited and responds verbally to any issues raised. Her response is documented in the minutes. She reported she only provides a written response to certain issues or concerns raised, not to all. [s. 57. (2)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the advice of the Resident's Council is sought in the development and carrying out of the satisfaction survey, and acting on its results.

The ED stated that the annual satisfaction survey is developed at the corporate level. The home is given a survey and the Residents Council, is not involved in the development or carrying out of the survey. [s. 85. (3)]

2. The licensee failed to seek the advice of the Family Council in developing and carrying out the satisfaction survey.

The President of the Family Council (PFC) stated that the licensee did not seek the advice of the Family Council (FC) prior to distributing the satisfaction survey, which went out to residents the middle of September 2014.

The Director of Programs and Admissions (DPA), who acts as the assistant to the FC stated that there was no meeting or discussion with the FC with respect to development or carrying out of the satisfaction survey prior to distributing the survey to the residents. The DPA stated that the survey is delivered from the corporate office in a box to be distributed to the residents.

The ED stated that the satisfaction survey is developed at the corporate level and the Family Council, is involved in the development or carrying out of the satisfaction survey. [s. 85. (3)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed no later than one business day after the occurrence of the incident of an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to hospital.

Related to Log #O-003346-14:

On an identified date, Resident #41 fell in the doorway of another resident's room, resulting in injury that required transfer to hospital and subsequent surgery. The Director was informed through the Critical Incident System 7 days later of the incident. Interview conducted with the DOC on October 22, 2014 confirmed the date of the Critical Incident, that this incident should have been reported within 1 business day and that the Critical Incident submission was greater than 1 business day. [s. 107. (3)]

Issued on this 18th day of November, 2014

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