**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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Apr 8, 2016 | 2016_389601_0006 | 001891-16 | Complaint |

### Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Case Manor Care Community
28 BOYD STREET P.O. BOX 670 BOBCAYGEON ON K0M 1A0

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

KARYN WOOD (601)

## 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): March 23, 2016.**

**This Complaint Inspection #001891-16 is related to a complaint regarding resident care and continence care.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Resident Care Coordinator (RCC), the Physiotherapist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Worker (PSW), a Resident and their family member.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Skin and Wound Care**

**During the course of this inspection, Non-Compliances were issued.**
**1 WN(s)**
**0 VPC(s)**
**0 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
**(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #001's medical equipment so that their assessments were integrated, consistent and complement each other.

On an identified date, the Physiotherapist documented in resident #001's progress notes one day after the resident was admitted to the home that resident #001 required identified medical equipment to meet the resident's basic daily needs.

During an interview, the Physiotherapist indicated that resident #001 had two Power of Attorney's (POA).

Review of resident #001's progress notes indicated that four days after admission to the home, the Physiotherapist spoke to resident #001's POA #01 about replacing the identified medical equipment due to not being the appropriate size for the resident. Review of the same progress note eight days following admission to the home also indicated the Physiotherapist had discussed resident #001's medical condition with POA #01. At this time, resident #001's POA #01 authorized the Physiotherapist to contact an identified vendor to request a trial of the identified medical equipment to meet resident #001's specific needs.

During an interview and review of resident #001's progress note dated approximately two months after the resident was admitted to the home, the Resident Care Coordinator (RCC) indicated the vendor had communicated that the identified medical equipment was on back order and was scheduled to be delivered in approximately twenty days. The RCC provided resident #001 with an alternative to the identified medical equipment and POA #02 was notified by RN #102. During an interview, the Physiotherapist indicated not assessing resident #001's comfort with the alternative identified medical equipment provided to resident #001.

Review of resident #001's progress notes for approximately a four month period identified that the Physiotherapist communicated with the vendor approximately one month after the identified medical equipment was ordered, and on three identified dates the second month after the identified medical equipment was ordered and documented that the identified medical equipment had not arrived. Resident #001's progress note

indicated the Physiotherapist left a message on resident #001's POA #01 voice mail that the identified medical equipment had still not been delivered.

During an interview approximately four months after resident #001's identified medical equipment was ordered, resident #001 indicated the identified medical equipment currently being used was not comfortable and that it is taking too long to arrive.

On an identified date approximately three months after the identified medical equipment was ordered, the identified vendor representative delivered resident #001's identified medical equipment to the home. The RCC noticed that the identified medical equipment did not meet the resident's medical requirements and indicated verbally notifying the Physiotherapist two days after the identified medical equipment arrived.

During an interview on an identified date, the Physiotherapist indicated that resident #001's identified medical equipment was still on back order twenty-four days after the identified medical equipment had been delivered to the home.

During an interview, the Resident Care Coordinator (RCC) indicated that the vendor providing resident #001's identified medical equipment had been bought out by another vendor approximately at the time the identified medical equipment was delivered to the home.

During an interview, the Administrator indicated the Physiotherapist would normally contact the vendor if there was a concern with the identified medical equipment that had been prescribed. On an identified date, the multidisciplinary team discussed the communication breakdown between the RCC and Physiotherapist. The Administrator indicated calling the new vendor and arrangements were made for resident #001's identified missing medical equipment to be delivered.

Therefore, there was a breakdown in collaboration of care between staff related to resident #001's identified medical equipment as the Physiotherapist had not completed an assessment of resident #001's alternative identified medical equipment provided by the RCC on an identified date. On an identified date the identified medical equipment was ordered and remained on back order for over three months. On an identified date the identified medical equipment was delivered to the home and was missing an important part. On an identified date, twenty-four days after the identified medical equipment was delivered to the home the Physiotherapist indicated the identified medical equipment was still on back order and the RCC indicated the Physiotherapist had been

informed. [s. 6. (4) (a)]

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**Issued on this 8th day of April, 2016**

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

**Original report signed by the inspector.**