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 # / No de registre	Type of Inspection / Genre d'inspection
Jul 27, 2017	2017_682549_0002	006242-17, 014669-17	Complaint

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE LAURIER MANOR
1715 MONTREAL ROAD GLOUCESTER ON K1J 6N4

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

RENA BOWEN (549)

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): July 19, 20, 24, 25, 26, 2017

Log # 006242-17 is related to the provision of care, medication administration, nutrition and hydration and housekeeping supplies.
Log # 014669-17 is related to the provision of care and managing complaints.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Activity Aides, the Office Manager, the Receptionist, the Nursing Clerk, the Environmental Services Manager, the Dietary Supervisor, the Acting Assistant Director of Care, the Acting Director of Care (Acting DOC), the Director of Care and the Administrator.

The inspector observed the provision of care, two medication administration passes, the morning and afternoon nutrition pass, reviewed care staff schedules, Individual Monitored Medication Records for narcotics and controlled drugs, resident health care records, medication pass policy #CLIN 11-03 version October 2014, Individual Monitored Medication record policy #6-5 and Food and Fluid Intake Monitoring policy # RESI-05-02-05 version September 2014.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Medication
Nutrition and Hydration
Pain
Personal Support Services
Recreation and Social Activities
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **3 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or Regulations requires the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system is complied with.

O. Reg. 79/10, s.144 (2) requires that the licensee develops written policies and protocols for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

1. Inspector #549 was provided with a copy of Medical Pharmacies (the licensee's contracted pharmacy) medication policy titled Individual Monitored Medication Record #6 -5, dated February 2017 by the Acting Director of Care (Acting DOC) on July 19, 2017 who indicated that the policy is specifically for narcotics and controlled drugs. The Acting DOC also indicated that this policy is the policy that the licensee has implemented through the contracted pharmacy. The inspector reviewed the policy which stated under the procedure section, bullet three the following: Initial "received by" and "witnessed by" on the 'Individual Monitored Medication Record' in appropriate section at top of page. Document the TOTAL number of tablets, capsules, volume of liquid, number of patches or ampoule's received in the "QUANTITY/REMANING" bolded column, for each order received from the pharmacy.

Inspector #549 reviewed the Individual Monitored Medication Records for resident #002 for specific dates in 2017, for specific narcotics and controlled drugs . These Monitored Medication Records did not include a "witnessed by" initial for the received drugs from the pharmacy.

During an interview with the Director of Care (DOC) on July 24, 2017 it was indicated to the inspector that the Individual Monitored Medication Records are for narcotics and controlled drugs only. The records are to include a registered staff signature with the date, time and amount of the narcotic or controlled drug that was "received by" from the pharmacy with a registered staff signature in the "witnessed by" section.

After reviewing the current Individual Monitored Medication Records for the third floor which are kept in a binder in the locked medication cart Inspector #549 noted that 17 records on the third floor did not include a "witnessed by" signature for all of the 17 records and on the fourth floor the 27 records did not include a "witnessed by" signature.

The DOC indicated to Inspector #549 that the expectation is that the registered staff include a "witnessed by" signature on all Individual Monitored Medication Records when a narcotic or controlled drug is received from the pharmacy for a resident.

The licensee has failed to ensure that registered staff have complied with the licensee's contracted pharmacy policy titled Individual Monitored Medication Record.

2. This finding is related to Log # 06242-17

The Ministry of Health and Long Term Care Action Line received a complaint on a specific date in March 2017 indicating that RPN #124 brought resident #002's medications in a medication cup to the resident and put the medication cup on the over bed table next to the resident. The complainant indicated that the medication accidentally fell on the floor. The complainant also indicated that RPN #124 picked up the medication from the floor and gave them to the resident. The complainant indicated that resident #002 had told RPN#124 that one of the pills fell on the floor and that the following day a pain medication was found in the resident's room on the floor.

During an interview with PSW #119 on July 24, 2017 it was indicated to Inspector #549 that she was in resident #002's room at the time of the incident and that she did not witness RPN #124 pick medication up from the floor. PSW #119 indicated during the interview that resident #002's medication got knocked over on to the over bed table and the resident put the medication back in the medication cup. She also indicated that RPN #124 left the room before the resident took the medication to get the resident some yogurt.

During an interview with RPN #124 on July 25, 2017 she indicated that during the medication pass on a specific date in January 2017, that she handed resident #002's medication cup to the resident so that the resident could take the prescribed medications. At that time the resident asked for a specific items to take the medication with. RPN #124 indicated that the resident would not give the medication cup back stating to the RPN that she is not a child. RPN #124 then left the room without the medication asking the staff assigned to the nutrition pass who was in the hallway for the specific item for resident #002. The staff assigned to the nutrition pass indicated that resident #002's specific item was in the resident's room already. RPN #124 then indicated that she went back into the resident's room and the resident was taking the prescribed medication with the specific item that was left in the room. RPN #124 also indicated that resident #002 told her that one of the medications fell on the floor. RPN #124 and PSW #119 looked on the floor for any medication but could not find any. RPN #124 indicated to the inspector that she told the resident that all the medication that was prescribed to the resident must have been in the medication cup as there was nothing on the floor. The RPN indicated that she left resident #002's room to continue the medication pass. During the same interview RPN#124 indicated she did not pick up pills from the floor and give then to resident #002.

The DOC provided the inspector with the licensee's investigation documentation related to administering medication to resident #002 that had fallen on the floor. The investigation documentation indicated that the outcome of the investigation was that the DOC could not verify that RPN #124 picked medication up from the floor and administered them to resident #002. The licensee's investigation documentation also indicated that the social worker met with resident #002 on a specific date in January 2017, and that the resident indicated that he/she found a pain medication on the floor which the resident indicated that it must have been the lost one from the previous evening. The social worker gave the medication to the registered staff for destruction.

The DOC provided Inspector #549 with a copy of the licensee's Medication Management policy titled Medication Pass policy # CLIN11-03, version October 2014. Under the procedure section, bullet number 1. (vi), It is stated that the registered staff are to stay with the resident while the resident takes the medication.

The DOC indicated during an interview on July 26, 2017, that the expectation is that all medications are to be taken in front of the registered staff administering the medication, no medication is to be left with a resident.

The licensee has failed to ensure that the licensee's Medication Pass policy #CLIN 11-03 is complied with, in that RPN #124 did not stay with resident #002 while the resident took the prescribed medications on a specific date in January 2017. [s. 8. (1) (b)]

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 to ensure that medication policy titled Individual Monitored Medication Record #6-5 and policy titled Medication Pass #CLIN 11-03 are complied with, to be implemented voluntarily.

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 reassessments, interventions and resident's response to interventions are documented.

O. Reg. 79/10, s 33(1) the Nursing and Personal Support Services requires the licensee to ensure that each resident is bathed, at a minimum of twice a week by the method of her/his choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The Ministry of Health and Long Term Care Action Line received a complaint on a specific date March 2017. The complainant indicated that resident #002 did not receive a bath on a specific date in February and March 2017.

Resident #002 was admitted to the home on a specific date in 2016. The resident's plan of care in effect at the time of the complaint indicated that the resident is to have a shower every Friday and Monday and requires extensive assistance by one person.

Inspector #549 reviewed resident #002's PSW Daily Care Flow sheets for the period of December 2016 to March 2017. The resident should have received 16 showers. The documentation in the PSW Daily Care Flow sheets indicated that the resident received six showers during this time period. This includes no documentation on the specific date in February and March 2017 as indicated in the complaint. The PSW Daily Care Flow sheets indicated that the resident received a shower on a specific date in March 2017 the day after the resident's regular scheduled shower. There is no documentation indicating the reason the resident did receive a shower on the regular scheduled shower day.

Resident #002's progress notes where reviewed by the inspector for the specified time period, there is no documentation indicating that the resident refused a shower or was on a leave of absence.

2. Resident # 006 was admitted to the home on a specific date in 2016. The resident's current written Plan of Care (last reviewed on a specific date in July 2017) indicated the resident is to receive a tub bath Saturday days and Wednesday evening.

Resident #006's PSW Daily Care Flow sheets were reviewed by Inspector #549 for the time period of April 2017 to July 2017. There is no documentation on the PSW Daily Care Flow sheet for a specific date in April and on a specific date in May 2017 that the resident received a second bath, refused a second bath or was on a leave of absence. There is no documentation indicating that the resident received a second bath, refused a second bath or was on a leave of absence for a specific week in June or a specific week in July 2017.

Resident #006 should have received 12 baths between a specific time period in April and May 2017. The PSW Daily Care Flow sheets indicated that the resident received six baths in that time period. During a specific week in June and July 2017, resident #006 should have received four baths, the documentation on the PSW Daily Care Flow sheet indicated that the resident received two baths,

There is no documentation in the resident's progress notes indicating that the resident refused a second bath or was on a leave of absence for the specified time period in April

and July 2017.

2. Resident #007 was admitted to the home on a specific date in 2015. The resident's current Plan of Care (last revised on a specific date in July 2017) indicated the following: will bath or shower twice a week and as needed. Physical help provided in part of bathing activity: 2 staff to transfer to tub chair. One staff to wash the resident and complete bathing task.

Inspector #549 reviewed resident #007's PSW Daily Care Flow sheets for the period of May to July 2017. The is no documentation in the PSW Daily Care Flow sheet indicating that resident #007 received a second bath, refused a second bath or was on a leave of absence during the specified time period. There is no documentation that the resident received a second bath, refused a second bath or was on a leave of absence for the second specified time period.

Between the specified dates in May and June 2017 the resident should have received eight baths the documentation in the PSW Daily Care Flow sheet indicated that the resident received four baths. Between another specified time period the resident should have received two baths, the documentation in the PSW Daily Care Flow sheet indicated that the resident received one bath.

There is no documentation in resident #007's progress notes between the specified dates indicating that the resident refused a second bath or was on a leave of absence.

During an interview on July 24, 2017 with PSW #107 and #116 indicated to Inspector #549 that every resident is to receive a minimum of two baths/showers a week and more if required. The PSW also indicated that they are to document in the PSW Daily Care Flow sheet that is kept in a binder at the nursing station when a resident receives or refuses a bath.

RPN #106, RN #105 and the Acting Director of Care (Acting DOC) indicated to Inspector #549 that the PSWs are to document in the individual resident's PSW Daily Care Flow sheet. The PSW Daily Care Flow sheets are kept in a binder at the nursing station. The Acting DOC indicated to Inspector #549 that the home's expectation is that all baths or showers are to be documented in the PSW Daily Care Flow sheet when given, refused or when the resident is on a leave of absence

The licensee has failed to ensure that all residents' baths or showers are documented

given, refused or the resident is on a leave of absence. [s. 30. (2)]

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 to ensure that all resident baths or showers are documented when given, refused or when the resident is away on a leave of absence, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a system to monitor and evaluate the food and fluid intake of residents with identified risk related to nutrition and hydration is complied with.

This finding is related to Log #014669-17 and Log # 006242-17

During an interview on July 24, 2017 the Dietary Supervisor indicated that the system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration is for the PSW to complete the Resident Daily Food and Fluid Intake sheet daily.

During an interview with the DOC on July 24, 2017 it was indicated to Inspector #549 that the PSW is to indicate the percentage of food the resident ate and the fluid intake for meals and nourishment's. If the resident is in hospital, sleeping or on a Leave of Absence this is to be documented on the Food and Fluid Intake sheet also. The registered staff are to sign at the bottom of the sheet indicating that the daily intake was reviewed.

1. On a specific date in June 2017 an email was sent to the Administrator related to resident #001's dentures missing and concern for the resident's nutritional health. The complainant was concerned that the resident's diet would change to pureed food which the resident is not fond of and will eat very little.

Resident #001 was assessed on a specific date in June 2017 to be a high nutritional risk, a reassessment was completed on a specific date in July 2017 by the home's Registered Dietitian to continue to be a high nutritional risk.

Inspector #549 reviewed resident #001's Food and Fluid Intake sheet for a specific period in July 2017. The Food and Fluid Intake sheets had no documentation on specific dates in July 2017 for any food or fluid intake for breakfast or lunch. The Food and Fluid Intake sheets for specific dates in July 2017 had no documentation for food and fluid intake for dinner and other specific dates in July 2017 there is no documentation of any food or fluid intake for lunch. There was no registered staff signature for the identified time period indicating that the registered staff have reviewed the resident's daily intake.

2. Resident #002 was assessed on a specific date in December 2016 to have no nutritional problems, a reassessment was completed on specific in March 2017 by the homes Registered Dietitian and was found to be a moderate nutritional risk.

Inspector #549 reviewed resident #002's Food and Fluid Intake sheet for a specific period in January and February 2017. The Food and Fluid Intake sheet had no documentation of any food or fluid intake for lunch on specific dates in January 2017 and

no documentation of any food or fluid intake for breakfast on a specific date in January 2017. The March 2017 Food and Fluid Intake sheets could not be located. None of the available Food and Fluid Intake sheets had a registered staff signature identifying that they resident's daily intake was reviewed.

3. Resident #004 was assessed on a specific date in June 2017 to be moderate nutritional risk and reassessed on a specific date in July 2017 to be a high nutritional risk.

Inspector #549 reviewed resident #004's Food and Fluid Intake sheets for a specific period in July 2017. The Food and Fluid intake sheet for specific dates in July 2017 had no documentation of any food and fluid intake for breakfast and lunch. There was no registered staff signature for the identified time period indicating that the registered staff reviewed the resident's daily intake.

4. Resident #005 was assessed on a specific date in July 2017 to be a high nutritional risk and reassessed on another specific date in July to remain at a high nutritional risk.

Inspector #549 reviewed resident #005's Food and Fluid Intake sheet for a specific period of July 2017.

The Food and Fluid Intake sheet specific dates in July 2017 had no documentation of any food or fluid intake for breakfast, lunch or morning nourishment. Another specific date in July 2017 had no documentation of any food or fluid intake afternoon nourishment or dinner. There was no registered staff signature for the identified time period indicating that the registered staff reviewed the resident's daily intake.

During an interview on July 25, 2017 the Registered Dietitian indicated to Inspector #549 that the PSWs are not completing the Food and Fluid Intake sheets as required.

During an interview with the DOC on July 25, 2017 it was indicated to Inspector #549 that the PSWs are expected to document resident food and fluid intake after meals, snacks and nourishment's including any special items and nutritional supplements on the resident's individual Food and Fluid Intake sheet. The DOC also indicated that the expectation is for the registered staff to review resident food and fluid intake records daily and initial the Food and Fluid Intake sheet daily. [s. 68. (2) (d)]

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 to ensure that the resident's Food and Fluid Intake sheets are completed daily, to be implemented voluntarily.

WN #4: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

This finding is related to Log #014669-17

Resident #001 was admitted to the home on a specific date in 2013.

Resident #001's Minimum Data Set (MDS) assessment dated a specific date in June 2017 indicated that the resident has short term and long term memory problems and cognitive skills for daily decision-making is moderately impaired decisions are poor, cues or supervision is required.

The current written Plan of Care (revised on a specific date July 2017) indicated under Focus: Eating and swallowing the following intervention is required: dentures in at 0700 hours and remove only at bedtime.

Focus: Dental Status Natural teeth loss and have dentures. (Still missing top dentures as of a specific date in June 2017). Intervention: Registered staff have to put the dentures in the morning 0700 & remove at bedtime. Resident has new dentures labelled. Resident has a tendency to lose them by misplacement.

During an interview on July 20, 2017, RPN #106 indicated to Inspector #549 that resident #001's dentures have been missing since a specific date in June 2017 and are still missing. RPN #106 indicated that a complete search of the unit was completed however the dentures could not be found. The RPN also indicated that resident #001 has put his/her dentures in the garbage and in the linen in the past but the staff were able to retrieve them.

Inspector #549 reviewed the progress note for a specific date in June 2017 which indicated that resident #001's dentures could not be located. Review of the progress note dated a specific date in June 2017 indicated that the evening PSW could not find the resident's dentures to give the registered staff. Review of a progress note dated a specific date in July 2017, indicated that the resident's dentures went missing on a specific date in June 2017.

PSW #107 who provided care to the resident #001 indicated on July 20, 2017 during an interview that the resident does not have dentures.

The DOC indicated during an interview with Inspector #549 on a specific date in July 2017 that resident #001's dentures have not be located since they went missing on a specific date in June 2017 and the plan of care does not reflect that the care set out in the plan of care is no longer necessary.

The plan of care was not revised when resident #001's dentures could not be located on a specific date in June 2017 and remain missing indicating that the care set out in the plan is no longer necessary. The resident no longer has dentures. [s. 6. (10) (b)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written complaint received by the home concerning the care of a resident or the operation of the long-term care home is immediately forward it to the Director.

This finding is related to Log #014669-17

On a specific date in September 2016 a complaint was hand delivered to the Long Term Care home address to the Manager of Programs related to the types of activities being provided to the resident by the activity department.

On a specific date in June 2017 an email complaint was sent to the Administrator related to resident #001's dentures missing and the resident's plan of care.

During an interview on July 20, 2017 the Administrator indicated to Inspector #549 that the licensee did not forward the written complaints received on the specific date in September 2016 or the specific date in June 2017 to the Director. [s. 22. (1)]

WN #6: 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).

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 is dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response is provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one of more residents, the investigation shall commence immediately.

This finding is related to Log #014669-17

Ministry of Health and Long Term Care (MOHLTC) Action Line received a call related to resident #001 on a specific date in July 2017. The MOHLTC Action Line Complaint Information Report indicated that the complainant has written two letters and one email to the Long Term Care home on two different issues but had received no response.

During an interview with the complainant on July 18, 2017, the complainant indicated to Inspector #549 that on a specific date in September 2016, she/he hand delivered a written complaint addressed to the Manager of Programs related to the types and quality of activities being provided to the resident by the activity department. On a specific date in February 2017 the complainant hand delivered a second written complaint to the Administration office related to the resident's dentures and the activities being provided by the recreation department. On a specific date in June 2017 an email was sent to the Administrator from the complainant again indicating an issue with the resident's dentures, this time the dentures went missing and the complainant's concern with the resident's nutritional health due to not having dentures.

During an interview with the Program Manager on July 19, 2017 it was indicated to the inspector that the complaint letter related to the types of activities being provided to the resident was received from the complainant and that a response was not provided within 10 days of receipt of the complaint.

The Administrator indicated during an interview on July 19, 2017 that she was unaware of the complaint letter received from the complainant on a specific date in September 2016 related to the type of programs being provided to resident #001.

The Administrator also indicated during the same interview that she does not recall a complaint letter hand delivered from the complainant dated a specific date in February 2017 and was not able to locate it. The Office Manager and the Receptionist indicated during an interview on July 23, 2017 with the inspector that they do not recall a letter being left addressed to the Administrator on a specific date in February 2017. The Director of Care (DOC) indicated during an interview with the inspector on July 24, 2017, that she does not recall a letter being left addressed to the Administrator on a specific date in February 2017.

The Administrator indicated that the she did receive an email on a specific date in June 2017 from the complainant related to the resident’s missing dentures and the concern about the resident's nutritional health. The Administrator indicated that the email was sent forward to the DOC requesting that the complaint be investigated.

During an interview with the DOC on July 24, 2017 she indicated that she was aware of the complaint email from the complainant and an investigation was conducted on a specific date in June 2017. The DOC indicated to Inspector #549 that the complainant did not received a response to the complaint until July 2017.

The licensee received a complaint letter on a specific date in September 2016 and on a specific date in June 2017 from the complainant . The licensee failed to respond to the complainant within 10 days of receipt of the complaint letters. [s. 101. (1) 1.]

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Ministry of Health and Long-Term Care

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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

Issued on this 14th day of August, 2017

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

Original report signed by the inspector.