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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 2, 2015	2015_264609_0047	011531-15, 013956-15, 013113-15, 011911-15	Critical Incident System

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF GREY
206 Toronto Street MARKDALE ON N0C 1H0

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

GREY GABLES HOME FOR THE AGED
206 TORONTO STREET SOUTH MARKDALE ON N0C 1H0

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

CHAD CAMPS (609)

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): September 4, 8, 9, 10, 29, 30, 2015

This inspection is being conducted related to four Critical Incident Reports submitted to the Ministry of Health and Long Term Care related to staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Long Term Care, the Director of Care (DOC), the Recreation Manager, two Registered Nurses (RN), two Registered Practical Nurses (RPN), three Personal Support Workers (PSW), and two family members of residents.

The inspector(s) also reviewed clinical records, internal investigation reports, policies and procedures of the home, and plans of care.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
2 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. (3) The licensee shall ensure that the plan of care covers all aspects of care, including medical, nursing, personal support, nutritional, dietary, recreational, social, restorative, religious and spiritual care. 2007, c. 8, s. 6 (3).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the plan of care covered all aspects of care, including medical, nursing and personal support care.

A review of a Critical Incident Report revealed that on a specified day a specified piece of equipment was not properly working for an identified resident.

An interview with Registered staff confirmed that ensuring the specified equipment was properly working was a task delegated to the Personal Support staff.

An interview with Personal Support staff confirmed that ensuring the specified equipment was properly working was a task delegated to Personal Support staff and that there was no identification of this resident specific task in the plan of care, kardex, or Point of Care.

A review of the home's policy titled "Documentation-Resident Records" approved September 2013, indicated documentation is maintained on each resident to demonstrate the provision of care and service that meet the individualized needs of the resident.

An interview with the Administrator and the Director of Long Term Care confirmed that it was the expectation of the home that the plan of care covered all aspects of care, including the daily personal support task of ensuring the specified equipment was properly working, to meet the individualized needs of the identified residents, that currently the home did not cover this aspect of care or provision of care in the plans of care for these identified residents and should have. [s. 6. (3)]

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 plan of care covers all aspects of care, including medical, nursing and personal support care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the responsive behaviour plan of care included any identified responsive behaviours.

A review of a Critical Incident Report revealed that on a specified day an identified resident demonstrated responsive behaviours.

A review of clinical records revealed that on two previous instances the identified resident had two other episodes of responsive behaviour.

An interview with the Behavioural Supports Ontario RPN revealed that the identified resident had identified responsive behaviours.

A review of the plan of care for the identified resident revealed no mention of the identified responsive behaviour and no development or implementation of strategies to respond to the behaviour.

An interview with the DOC confirmed that it was the home’s expectation that identified responsive behaviour are to be identified on the plan of care, that the responsive behaviour of the identified resident was not identified or care planned and should have been. [s. 26. (3) 5.]

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 responsive behaviour plan of care includes any identified responsive behaviours, to be implemented voluntarily.

Issued on this 22nd day of October, 2015

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

Original report signed by the inspector.