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
Mar 3, 2017	2017_448155_0002	002883-17	Complaint

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

SHARON PERRY (155)

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): February 6, 9, 10, 14, 15, 16 and 17, 2017.

Intake log 002697-17 / CI M606-000002-17 critical incident of alleged improper/incompetent treatment of a resident that resulted in harm or risk to a resident was completed within this complaint inspection regarding alleged retaliation.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Office Manager, Labour Relations Officer, Registered Nurse, Registered Practical Nurses, Personal Support Workers, Dietary Aides and residents.

The inspector also reviewed relevant clinical records, policies and procedures, schedules, internal investigation notes, employee file; observed the provision of resident care, medication administration, meal service, and resident-staff interactions.

The following Inspection Protocols were used during this inspection:
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 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 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 were documented.

Record review showed that on an identified date, a resident was not feeling well.

On an identified date and time, a resident was given medication by mouth for a specific concern. They continued to have symptoms.

Approximately eleven hours later, it was documented that the medication given by mouth for a specific concern had been effective. Review of the vital signs section of the resident's record showed that the resident's vitals were recorded and some of the vitals were noted to be below the resident's usual range.

The Director of Care shared that the Registered Nurse that documented that the medication was effective and recorded the vitals for the resident should have documented a progress note in point click care indicating the vital signs as well as an assessment of the resident. The Director of Care also shared that interventions should have been put in place and the physician notified.

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 were documented. [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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

Review of a resident's care plan stated that for eating, the resident was to be provided with certain assistive devices.

During observation of the lunch meal, the resident was observed to have some of the assistive devices identified in their care plan available for use. The resident was observed at times to eat on their own and at other times during the same meal required staff to feed them. An identified Personal Support Worker encouraged the resident to eat and drink and assisted them when needed. The resident was observed during meal to cough at times. The resident was observed to try to take a drink and tilted their head back to get the fluids. The resdient then started to cough.

When the identified PSW was questioned about the assistive devices that the resident was using, they shared that the resident was to have an assistive device but it was forgotten. The PSW then went and obtained the assistive device and gave it to the resident. The resident was observed using the assistive device and no coughing was noted.

The licensee failed to ensure that the resident was provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. [s. 73. (1) 9.]

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 home has a dining and snack service that includes, at a minimum , providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs
Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and
(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.

Findings/Faits saillants :

1. The licensee has failed to ensure that no medical directive or order for the administration of a drug to a resident was used unless it was individualized to the resident's condition and needs.

An identified resident was observed sitting in the dining room awaiting their lunch meal. The resident was observed to have a specific treatment in place.

Record review showed that on an identified date, a Registered Nurse went to assess the resident as a Personal Support Worker had reported that the resident had been ill. The resident was assessed by the Registered Nurse and found that the resident had a vital sign lower than their normal range. Treatment was started and the resident's vital sign improved.

Record review also showed that the resident had an improved vital sign when treatment was provided.

Review of the resident's physician orders and medical directives (individualized resident care orders) showed that there was no order for the specified treatment. The Director of Care shared that there should have been an order obtained from the physician.

The licensee failed to ensure that no medical directive or order for the administration of a drug to a resident was used unless it was individualized to the resident's condition and needs. [s. 117. (b)]

Issued on this 10th day of April, 2017

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

Original report signed by the inspector.