Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
April 12, 13, 16, 2012	2012_067171_0010	Complaint – H-00043-12

Licensee/Titulaire

Deem Management Service Limited, 2 Queen Street East, Suite 1500, Toronto, ON, M5C 3G5

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

Hamilton Continuing Care, 125 Wentworth Street South, Hamilton ON, L8N 2Z1

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

Elisa Wilson (171)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection.

During the course of the inspection, the inspector spoke with: the administrator, assistant director of care, registered dietitian, registered staff, personal support workers, food service supervisor, and laundry staff.

During the course of the inspection, the inspector: reviewed the plans of care for identified residents and reviewed home policies.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Nutrition and Hydration

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

2 WN
2 VPC

This inspection was conducted concurrently with Inspection 2012_067171_0009 (H-00627-12)

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights.

Specifically failed to comply with the following subsections:

s.3(1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

Findings:

1. The licensee did not ensure that every resident was treated with courtesy and respect in a way that fully recognizes the resident's individuality and respects the resident's dignity.

A resident was observed receiving morning care by a staff person. The resident was resisting care being provided, however the staff person continued to provide care. The resident's plan of care indicated that if care was resisted the staff person should stop and try again in 5-10 minutes. The staff person did not treat the resident with courtesy and respect by continuing the activity against the resident's wishes.

The administrator confirmed the expectation that staff are to treat residents respectfully when they refuse care and that the plan of care interventions support respectful approaches to care.

PLEASE NOTE: This evidence of non-compliance was found during inspection 2012_067171_0009.

2. The licensee did not fully respect and promote the residents right to be properly cared for in a manner consistent with her needs.

A staff person had started personal care with a resident however did not complete the care during the shift. This worker left the building and the remaining staff were unaware that the resident required further care. The job description for this shift indicated at the end of the shift "ensure co-workers are aware of the resident care that was provided". The registered staff and administrator confirm this information should have been passed on to the remaining staff at the time the worker left.

Inspector ID #:	171

Additional Required Action:

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 residents are treated with courtesy and respect and are cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #2: 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 subsections:

s.6(7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Findings:

The licensee had not ensured that care was provided to the resident as specified in the plan of care.

1. The plan of care for a resident indicated that two staff were required to provide morning care at all times and if the resident refused care to stop and re-approach in 5-10 minutes. The resident was observed by an individual to be receiving morning care by only one staff person. The resident was observed to be resisting care, however the staff person continued to provide the care. Registered staff and personal support workers confirmed the expectation was two staff should provide care at all times and if the resident resists care to stop and come back later to try again.

   PLEASE NOTE: This evidence of non-compliance was found during inspection 2012_067171_0009.

2. The plan of care for another resident included a consent form for a specific medication. The form had the "no" checked off for this medication to indicate it was not approved and was signed by the resident's power of attorney. The medication was administered to the resident on a specific day as per the resident's request; however this was not discussed with the resident's power of attorney before proceeding, as per the plan of care. The progress notes and medication administration record confirm the medication was given. The assistant director of care and the administrator confirmed the medication should not have been provided to the resident without consultation and agreement with the resident's power of attorney for personal care.

Inspector ID #:	171

Additional Required Action:

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 care is provided as specified in the plan of care, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné		Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. Elisa Wilson
Title:	Date:	Date of Report: (if different from date(s) of inspection). May 8, 2012