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 prévue 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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 23, 2018	2018_414110_0016	012036-17, 028958-17	Complaint

Licensee/Titulaire de permis

Poranganel Holdings Limited
2231 Medhat Drive MISSISSAUGA ON L5B 2E3

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

King City Lodge Nursing Home
146 Fog Road King City ON L7B 1A3

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

DIANE BROWN (110)

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): October 16, 17, 18, 19 and 22, 2018.

During this inspection the following complaint intakes were completed:
Log #012036-17 and log# 028958-17 related to lack of care provided.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Registered Nurses (RN), Nurse Manager (NM), Personal Support Workers (PSW), physician and residents.

The following Inspection Protocols were used during this inspection:
Personal Support Services

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

- **1 WN(s)**
- **1 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	Légende 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. (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).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

On an identified date a complaint was received by the Ministry of Health and Long Term Care (LTC) related to a concern that resident #001 had been unwell for an identified number of days before anyone from the LTC home notified the family and that the resident did not receive proper care.

A record review identified family member #111 as resident #001's Substitute Decision Maker (SDM).

During a telephone interview with SDM #111 they shared they frequently visited the resident in the home but a few days leading up to the resident's decline in health they had not gone into the home. The SDM revealed they received a call from RN #104 indicating the resident was not feeling well. The SDM stated that after the call they visited the resident and it was at this time they learned the resident had not been well for an identified number of days prior to the call. The SDM revealed that they initiated the

transfer of the resident to hospital for further assessment.

A record review of the identified hospital medical record report for the identified date of admission indicated that resident had an identified diagnosis and had declined over an identified number of days. A review of progress notes and physician orders between an identified three day period documented that resident #001 presented with identified symptoms and that medication had to be administered as well as an identified intervention.

A review of the health care records and documented summary of the resident indicated the resident had a notable decline in health between day 1 (onset of symptoms) to day 3 (day of hospitalization). During this time period the resident was assessed by registered staff and changes of condition were documented. The resident continued to receive medication as required and an identified intervention.

An interview with the home's physician #110 identified that they had not been notified of the resident's change in condition prior to the families request to transfer the resident to the hospital.

A record review of the resident's health record over an identified three day period of time and staff interviews with nurse manager #106, RN #109, RN #108, RN #107, RN #104, physician #110 and the DOC revealed there was a lack of collaboration with the physician in the assessment of resident #001's health status prior to resident's transfer to hospital.

2. The licensee failed to ensure that the resident, the SDM, if any, and the designate of the resident /SDM been provided the opportunity to participate fully in the development and implementation of the plan of care.

On an identified date a complaint was received by the Ministry of Health and Long Term Care (LTC) related to a concern that resident #001 had been unwell for an identified number of days before anyone from the LTC home notified the family and that the resident did not receive proper care.

During a telephone interview with SDM #111 they shared they frequently visited the resident in the home but a few days leading up to the resident's decline in health they had not gone into the home. The SDM revealed they received a call from RN #104 indicating the resident was not feeling well. The SDM stated that after the call they

visited the resident and it was at this time they learned the resident had not been well for an identified number of days prior to the call. The SDM revealed that they initiated the transfer of the resident to hospital for further assessment.

A record review of the identified hospital medical record report for the identified date of admission indicated that resident had an identified diagnosis and had declined over an identified number of days. A review of progress notes and physician orders between an identified three day period documented that resident #001 presented with identified symptoms and that medication had to be administered as well as an identified intervention.

A record review of the resident's health record over an identified three day period of time and staff interviews with nurse manager #106, RN #109, RN #108, RN #107, RN #104, physician #110 and the DOC revealed that the licensee failed to ensure that the resident's SDM had been provided the opportunity to participate fully in the development and implementation of resident #001's plan of care with respect to notifying the family of the resident's change in health condition when symptoms occurred, new medication administration and an identified intervention.

3. The licensee failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan.

On an identified date a complaint was received by the Ministry of Health and Long Term Care (LTC) related to a concern that resident #001 had been unwell for an identified number of days before anyone from the LTC home notified the family and that the resident did not receive proper care.

A review of progress notes between an identified three day period documented that resident #001 presented with a change in health condition. On day two of the resident's change in condition a record identified a Physician's Digorder with an identified medication order.

The following day, a progress note, documented by RN #105, revealed an assessment and the resident's need for an identified medication order.

An interview with RN #105 revealed they were unaware that the identified medication order was in place on day two.

An interview with the DOC confirmed that the resident's plan of care included orders written in the Physician's Digorder and that RN #105 had not referred to these orders and the care set out in the resident's plan of care was not provided as the identified medication was not administered. [s. 6. (7)].

4. On an identified date a complaint was received by the Ministry of Health and Long Term Care (LTC) related to a concern that resident #001 had been unwell for an identified number of days before anyone from the LTC home notified the family and that the resident did not receive proper care.

A record review identified family member #111 as resident #001's SDM. A review of the Advance Directives/Consent to Level of Treatment form, updated on an identified date directed staff to initiate an identified treatment, which stated if symptoms indicate the resident would be transferred to an acute care hospital for treatment.

An interview with Nurse Manager #106 revealed that the advance directives/consent to level of treatment were part of the resident's plan of care and why they were updated annually at the care conference.

During a telephone interview with SDM #111 they shared they frequently visited the resident in the home but a few days leading up to the resident's decline in health they had not gone into the home. The SDM revealed they received a call from RN #104 indicating the resident was not feeling well. The SDM stated that after the call they visited the resident and it was at this time they learned the resident had not been well for an identified number of days prior to the call. The SDM revealed that they initiated the transfer of the resident to hospital for further assessment.

A review of the health care records and documented summary of the resident indicated the resident had a notable decline in health between day 1 (onset of symptoms) to day 3 (day of hospitalization). During this time period the resident was assessed by registered staff and changes of condition were documented. The resident continued to receive medication as required and an identified intervention. The record review identified documentation that the family, while present with the resident, directed the transfer of the resident to the hospital.

A record review of the identified hospital medical record report for the identified date of admission indicated that resident had an identified diagnosis and had declined over an identified number of days.

An interview with the home's physician #110 identified that they had not been notified of the resident's change in condition prior to the families request to transfer the resident to the hospital.

The home failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan by way of failing to initiate the resident's advance directive. [s. 6. (7)]

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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other; that the resident, the SDM, if any, and the designate of the resident /SDM been provided the opportunity to participate fully in the development and implementation of the plan of care and the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 13th day of December, 2018

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

Original report signed by the inspector.