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
Dec 22, 2016	2016_303563_0041	029700-16, 032117-16, 032509-16	Complaint

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF LAMBTON
789 Broadway Street WYOMING ON N0N 1T0

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

LAMBTON MEADOWVIEW VILLA
3958 PETROLIA LINE R. R. #4 PETROLIA ON N0N 1R0

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

MELANIE NORTHEY (563), SHERRI COOK (633)

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): November 18, 21, 22, 23, 24, 28 and 29, 2016

The following intakes were completed within the Complaint Inspection
029700-16 - M547-0000015-16 - Critical Incident related to suspected staff to resident neglect
021103-16 - 2628-0000017-16 - Critical Incident related to suspected staff to resident neglect
032117-16 - IL-47860-LO - Complaint related to suspected staff to resident neglect
032509-16 - IL-47953-LO - Complaint related to suspected staff to resident neglect

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing and Personal Care, the Resident Quality Improvement Coordinator, three Registered Nurses, four Registered Practical Nurses, seven Personal Support Workers, the Confidentiality Clerk, one ward clerk, one Recreation and Leisure Aide, three residents

The inspector also made observations of residents and care provided. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed.

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

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	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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

The resident's family member shared that the Personal Support Workers (PSWs) were not following the resident's care plan which stated that the resident was to be in bed by a certain time.

Record review of the current care plan in Point Click Care (PCC) for the sleep / rest pattern focus stated the resident had two different interventions related to bed routine.

The resident shared that the bedtime routine changed depending on what else was going on.

The Director of Nursing and Personal Care (DONPC) agreed the interventions for sleep and rest did not provide clear direction to staff in terms of what time the resident goes to bed. The DONPC also shared that although the care plan was updated at the time of the complaint, the care plan to address sleep and rest did not set out clear directions to staff and others who provided bedtime care to the resident.

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident related to bedtime care and routines. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Record review of the current plan of care indicated that the resident had used a particular device and there were no specific interventions in the plan of care.

Interview with the DONPC indicated that the interventions related to this particular device should be monitored and documented in the electronic treatment administration record (ETAR). The DONPC agreed that documentation for the resident's devices were not present on the ETAR or Point of Care (POC) to be monitored.

The licensee has failed to ensure that the interventions related to a particular device for resident #001 were documented. [s. 6. (9) 1.]

3. The licensee failed to ensure that the provision of the care was set out in the plan of care.

The resident's family member shared that on two occasions the resident's special treatment was not monitored and that the family member had to remind staff to monitor it.

Record review of a “Family/Resident Communication” progress note documented by the DONPC stated there was a discussion related to the special treatment and that staff will monitor and check the special treatment every two hours while in use to ensure adequate supply.

Record review of the current care plan for the resident documented a care focus related to a need for specific monitoring related to the special treatment.

The DONPC shared that there were no interventions in the care plan to direct staff as to when to check the special treatment and acknowledged that an intervention should have been added to the care plan that PSWs were to check it every two hours.

The licensee has failed to ensure that the monitoring and interventions related to the special treatment for resident #001 were documented. [s. 6. (9) 1.]

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 set out clear directions to staff and others who provide direct care to the resident and to ensure that the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

Issued on this 3rd day of January, 2017

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

Original report signed by the inspector.