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 # / No de registre	Type of Inspection / Genre d'inspection
Dec 8, 2017	2017_491647_0020	025958-17	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

Owen Hill Care Community
130 OWEN STREET BARRIE ON L4M 3H7

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

JENNIFER BROWN (647), JUDITH HART (513), VALERIE PIMENTEL (557)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): November 21, 22, 23, 24, 27, 28, 29, 30, December 5, 6, 2017

The following complaints were inspected concurrently with this inspection:
016503-15: related to improper care,
017658-15: related to air temperature and bathing,
022558-15: related to elevators, staffing levels, food and temperature in the home.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Co-Director of Care (CoDOC), Resident Relation Coordinator, Director of Environmental Services, Registered Nurses (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSW), Housekeepers, Residents, Family Members, and Substitute Decision Makers.

During the course of the inspection, the inspectors conducted observation in resident home areas, observation of care delivery processes including medication passes and meal delivery
services, and review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

2 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

During Stage 1 of the Resident Quality Inspection (RQI), resident #004 indicated in an interview that he/she was transferred sometimes with the assist of two staff members and at other times with a mechanical lift with two staff. He/she revealed he/she has lost much of his/her functional ability for transfers now that the home has made him/her a two person mechanical lift transfer.

A review of the written plan of care identified the following interventions:
-Activities of daily living for transfers identified to assist with two staff and a mechanical lift for all transfers, and toileting to use two staff assist with use of a mechanical lift.

Interview with Direct care staff member #110 confirmed that staff use a mechanical lift to transfer the resident to the toilet on his/her bath days, otherwise, he/she is not taken to the toilet at any other time. He/she confirmed they do not do a two person transfer to the toilet or in and out of bed, however they assisted by a mechanical lift for all transfers.

Interview with the Assistant Director of Care (ADOC) and Director of Care (DOC) confirmed that the directions for transferring from bed to chair and or toilet for resident #004 in the written plan of care was conflicting and does not provide clear directions to the staff and others who provide direct care to resident #004. [s. 6. (1) (c)]

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: 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:

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. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity.

A complaint was received for resident #021, on an identified date, concerning the removal of the heating/cooling unit controls. The resident no longer resides in the home.

A record review for resident #021 revealed he/she had a mild cognitive decline. He/she controlled the Heating, Ventilation, Air Conditioning (HVAC) unit located at his/her bedside.

On an identified date, a review of the progress notes revealed the ED spoke with the resident #021’s Power of Attorney (POA) regarding concern about knobs being removed from resident #021’s HVAC unit on an identified date.

A review of the maintenance records for on an identified date, and interview with the ESM revealed the knobs of the HVAC unit were removed on an identified date, and replaced the following day.

An interview with Registered staff member #116 revealed resident #021 liked the room warmer, could see the knobs and would adjust the thermostat.

An interview with Registered staff member #118 revealed direct care staff member #119 was observed in the hallway on the identified date, with an air conditioning/heater unit knob in his/her hand.

Direct care staff member #119 was not available for interview. A review of investigation notes by the ED revealed direct care staff member #119 removed the knobs because the room was too hot.

An interview with the DOC and ED confirmed the knobs of the heating/air conditioning unit had been removed by direct care staff member #119 and the resident’s right to be treated with courtesy and respect and in a way that fully recognized their individuality and respected their dignity was not upheld. [s. 3. (1) 1.]

Issued on this 8th day of December, 2017

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

Original report signed by the inspector.