Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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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
Dec 16, 2019	2019_545147_0022	018658-19	Other

Licensee/Titulaire de permis

Retirement Home Specialists Incorporated
120 Conception Bay Highway Suite 110, Villa Nova Plaza Conception Bay South ON A1W 3A6

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

Morriston Park Nursing Home
7363 Calfass Road, R.R. #2 PUSLINCH ON N0B 2J0

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

LALEH NEWELL (147), DANIELA LUPU (758), KIYOMI KORNETSKY (743)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): December 9, 10 and 11, 2019.

This inspection was a Service Area Office Initiated Inspection (SAO II).

The following intake was completed in this SAO II Inspection: Log #: 018658-19.

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Care (DOC), Assistance Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Resident Council President and other residents.

The inspectors toured the home and observed dining service and medication administration. Resident care, services and activities were also observed. Clinical records and plans of care for identified residents were reviewed. Also, relevant documents were reviewed including but not limited to the home's documentation and procedures as related to the inspection.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Medication
Reporting and Complaints
Residents' Council
Skin and Wound Care

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. (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. (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 has failed to ensure that the written plan of care for residents #001 and #008 set out clear directions to staff and others who provide direct care.

A. A mandatory Falls Prevention Inspection Protocol (IP) was completed during a Service Area Office Initiated Inspection (SAO II) for resident #001. The resident had been identified to be at risk for falls and had falls prevention strategies in place for safety.

A review of the clinical records showed that the resident required a specific assistive device for an activity of daily living.

Resident #001's care plan and directions posted at the bed side were reviewed and indicated that the resident required these devices at all times as part of their falls prevention strategies.

During an interview with PSW #108, they stated that the devices where to be used at all times for a specified activity of daily living. PSW #108 acknowledged that the directions posted at the bed side were not updated and not clear.

In an interview with the home's Falls Lead, they acknowledged that the care plan was not updated and did not provide clear directions to staff regarding the use of the specified assistive devices for resident #001.

B. Observation of resident #008's bed showed that the resident had a specific device not in use. A sign posted at the bedside directed staff to apply the device as needed (PRN).

Review of the resident's care plan and clinical records showed that resident #008 required the device as PRN for the purposes of a specified activity of daily living.

In an interview with RN #106, they stated that resident #008 did not require the specific assistive device. RN#106 acknowledged that the directions in the care plan and direction posted at the bed side were not clear and needed to be revised.

The licensee has failed to ensure that the written plan of care for residents #001 and #008 set out clear directions to staff and others who provided direct care. [s. 6. (1) (c)]

2. The licensee shall ensure that the care set out in the plan of care for resident #002 was provided to the resident as specified in the plan.

The mandatory Skin and Wound Inspection Protocol (IP) was completed during a SAO II for resident #002. The resident had acquired an area of altered skin integrity. The resident was assessed and a specific device to assist with healing and off loading of pressure to the area was implemented.

Resident #002’s plan of care was reviewed and stated that no additional devices were to be used while the resident was in bed as it posed a risk.

Observation of the resident showed that there were additional devices added to the bed while the resident was using the assistive device. During an interview with staff #103 and #105, they acknowledged that the additional devices to the bed were not to be added while the resident was in bed as it posed a risk.

The licensee failed to ensue that the care set out in the plan of care for resident #002 was provided to the resident as specified in the plan. [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 ensue 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 and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 17th day of December, 2019

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

Original report signed by the inspector.