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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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 3, 2015	2015_355588_0031	016961-15	Complaint

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite #200 MARKHAM ON L3R 0E8

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

Secord Trails Care Community
263 WONHAM STREET SOUTH INGERSOLL ON N5C 3P6

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

CHRISTINE MCCARTHY (588)

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 28, 29, 2015

This inspection was conducted concurrently alongside Inspection Log #015364-15. This complaint was related to Plan of Care.

During the course of the inspection, the inspector(s) spoke with the resident, Registered Dietician, two Registered Practical Nurses, two Personal Support Workers, Director of Care, Administrator

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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. (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).

Findings/Faits saillants :

1. The licensee has 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.

Record review of the plan of care revealed that a specified family member was the POA-Care for resident #002 and had documented contact information available on the plan of care.

Record review revealed that on a specified date staff monitored resident #002 for changes in status.

Record review revealed that on a specified date, resident #002 had a change in medication as a result of the change in status.

Record review revealed that resident #002 was monitored for exhibiting abnormal signs and symptoms over a 9 day period, when they were admitted to hospital.

Record review revealed that the Power of Attorney (POA) was not notified of any changes in resident #002's status until the attending physician in the hospital informed them.

Interview with a registered staff revealed that the home's expectation was that changes in medications, treatments, and worsening condition should be communicated to the Power of Attorney for Care.

Interview with the Administrator confirmed that it was the expectation of the home to inform the person identified as the Power of Attorney for Care of any changes in status related to residents. [s. 6. (5)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

Observation of resident #002 over the noon hour on a specified day revealed the resident sitting in a wheelchair with the call bell laying at the opposite side of the bed, inaccessible to the resident.

Interview with a registered staff confirmed that the call bell was unattached and unaccessible to the resident and the expectation is that it should be accessible at all times. The registered staff readjusted the call bell so that it was accessible to the resident.

Observation of resident #002 at 1500 hours on the same specified day revealed the resident sitting in a wheelchair with the call bell laying at the opposite side of the bed, inaccessible to the resident.

Interview with a Personal Support Worker (PSW) revealed that the resident was not able to reach and access the call bell in its' current position and that the expectation of the home was that all call bells were to be accessible to residents. The PSW adjusted the resident and the call bell to make the call bell accessible. [s. 17. (1) (a)]

Issued on this 3rd day of December, 2015

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

Original report signed by the inspector.