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 sions 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
Apr 28, 2016	2016_457630_0009	001761-16; 009301-16; 010028-16; 010170-16; 002579-16	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

AMIE GIBBS-WARD (630)

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): April 12, 13, 14 and 15, 2016.

The following Complaint inspections were conducted concurrently during this inspection:
Log #001761-16 related to continence care products, power outage, sufficient staffing
Log #009301-16 related to continence care products
Log #010028-16 related to continence care products
Log #010170-16 related to continence care products
Log #002579-16 related to power outage

Inspector #634 (Adam Cann) was also present during this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Assistant Director of Care, Food Services Supervisor & Environment Services Manager, Office Manager, nine Personal Support Workers (PSWs), one Registered Practical Nurse (RPN), fourteen residents and two family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

During an interview with an identified resident it was reported that there were times when staff had provided the resident with a product that was not the usual one worn.

Review of the plan of care for this resident showed that different parts of the plan of care directed staff to use different continence care products and all parts of the plan of care did not match.

The Assistant Director of Care (ADOC) confirmed that that the different parts of the plan of care did not all match the continence product care needs of the resident. The ADOC confirmed it was the expectation in the home that all parts of the plan of care for continence products would match and provide clear direction to staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care for eating reviewed and revised when the resident's care needs changed.

Observations of an identified resident in the dining room during multiple meals during the inspection found this resident had difficulties eating without assistance from staff.

Interview with a Registered Practical Nurse (RPN) verified that this resident required assistance with eating.

Review of the documented care provided to this resident over a two week time frame showed this resident needed eating assistance from staff for at least 38 per cent of meals.

The Assistant Director of Care (ADOC) confirmed the level of eating assistance listed in the plan of care did not match the current assistance required by the resident. The ADOC confirmed it was the expectation in the home that the plan of care for eating would be updated when a resident's need changed. [s. 6. (10) (b)]

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 with ensuring the plan of care provides clear direction and that the plan of care is reviewed and revised when the care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all alarms for doors leading to the outside were connected to a back-up power supply and that staff monitored the doors leading to the outside of the home during a power outage.

There were complaints made to the Ministry of Health and Long Term Care (MOHLTC) related to the home's response to a power outage in the home that occurred in January 2016.

Interviews with the Executive Director (ED) and the Environmental Services Manager (ESM) confirmed the home had a power outage in January 2016. The ESM indicated the home did have a small generator but the locks and alarms for the doors leading to the outside were not connected to this power source. The ESM reported that during the power outage there was not enough staff available to monitor all doors exiting the home and a small sofa had been pulled in front of the main entrance to help prevent residents from leaving.

Interview with the ED and the ESM confirmed that all alarms for doors leading to the outside of the home were not connected to the back-up power supply and during the power outage in January 2016, staff did not monitor the exit doors in accordance with the procedures set out in the emergency plans. [s. 9. (1) 4.]

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 with ensuring the alarms for leading to the outside are connected to a back-up power supply or that staff monitor the doors according to the procedures set out in the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure there was a range of continence care products available and accessible to residents and staff at all times and in sufficient quantities for all required changes.

There were multiple complaints made to the MOHLTC related to the availability of continence care products in the home during March 2016.

Review of staff documentation for an identified resident showed the usual continence care product used by this resident was not available on a specified day in March 2016. The documentation also showed staff used different continence care products for this resident than what was specified in the plan of care.

Interviews with four Personal Support Workers (PSWs) revealed there were multiple days in March when they did not have continence care products available in the home and they had to use the wrong product on residents.

Review of the continence product invoices showed the home ordered fewer products for use in March compared to February.

The Director of Care (DOC) and Assistant Director of Care (ADOC) confirmed there was a period in March 2016 when not all continence care products needed by residents were available in the home.

Interview with ED acknowledged that it was the expectation in the home that there would be a range of continence care products available and that residents would receive the continence product they required. [s. 51. (2) (f)]

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 with ensuring there is a range of continence care products available in the home at all times, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques were used to assist residents with eating.

Observations in the dining room during two meal services found staff standing while assisting an identified resident with eating and drinking.

Interview with a RPN confirmed that staff had been standing while providing assistance to this resident.

Interview with DOC and ED acknowledged it was the expectation that staff would be sitting with residents when assisting and training had been provided for staff about proper feeding techniques. [s. 73. (1) 10.]

2. The licensee has failed to ensure that residents who required assistance with eating or drinking were only served a meal when someone was available to provide the assistance.

1) Observations in the dining room during multiple meals found an identified resident was served food prior to receiving the assistance required with eating.

Interview with ADOC confirmed it was the expectation in the home that residents who require assistance with eating receive that assistance in a timely manner.

2) Observations in the dining room during two breakfast meals found an identified resident was served fluids and food prior to receiving the assistance required with eating and drinking.

Interview with DOC and ED identified that breakfast meal service started at 0830 hours but not all PSWs were in the dining room to start assisting at that time and there tended to be an influx of staff in and out of the dining room during the breakfast meal.

Interview with Food Services Supervisor (FSS) and ED acknowledged the breakfast mealtime was 0830-0930 hours and that staff did not ensure that residents who required assistance with eating were only provided meals when there was assistance available. [s. 73. (2) (b)]

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 ensuring proper techniques are used when assisting residents with eating and that residents who require assistance with eating or drinking are only served a meal when someone is available to provide the assistance, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the breakfast meal time protocol was complied with.

Interview with FSS and ED indicated the breakfast mealtime in the home was 0830-0930 hours and that some residents were not receiving the required assistance with eating during the home's established mealtime related to the availability of the PSW staff in the dining room during that time.

Review of the Resident Council Meeting Minutes dated February 26, 2016, indicated "reviewed the times of meals and snacks: 0830am – breakfast; 10am – snack".

Observations during two breakfast meal services identified that there were no PSWs who remained in the Activity Room Dining Room to assist residents with eating until after

0850 hours. There were residents observed to be in the dining room waiting for the meal and assistance when inspector arrived at 0823 hours who did not receive assistance according to the reviewed meal time.

Interview with the FSS and ED acknowledged it was the expectation in the home that residents should be provided their breakfast during the stated breakfast mealtime. [s. 8. (1) (b)]

2. The licensee has failed to ensure that the system in place to monitor the food and fluid intake of residents was complied with.

Review of the home's policy titled "Pleasurable Dining Policy VII-I-10.40" current version dated January 2015 indicated "The PSW will: 21) Note and record resident's intake for food and fluids on the food and fluid tracking sheets. The Food Graphic Tool/electronic documentation provide a guide to calculate consumption of food and fluids at each meal".

Observations during a lunch meal service found that the amount of food and fluid consumed by an identified resident did not match what was recorded by staff in the resident's chart. Staff were not observed recording food or fluid intake in the dining room during the meal.

The ED and DOC reported that the current process for monitoring intake of food and fluid at meals needed improvements as the PSWs recording the intake were not always the ones who assisted the residents or who were in the dining room at the end of meals. It was reported the staff were not using tracking sheets in the dining room but were working on developing laminated cards to use to record intake.

The ED confirmed it was the expectation in the home that staff would accurately document intake and that they were working in the home to improve this system. [s. 8. (1) (b)]

Issued on this 2nd day of May, 2016

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

Original report signed by the inspector.