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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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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
Jan 29, Feb 4, 6, 2015	2015_257518_0001	L-001654-14	Resident Quality Inspection

Licensee/Titulaire de permis

RICHMOND TERRACE LIMITED
284 CENTRAL AVENUE LONDON ON N6B 2C8

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

RICHMOND TERRACE
89 RANKIN AVENUE AMHERSTBURG ON N9V 1E7

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

ALISON FALKINGHAM (518), PATRICIA VENTURA (517), ROCHELLE SPICER (516)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 5, 6, 7, 8, 9, 12, 13, 14, 15, 2015

CIS 1149-000004-14 L-000385-14 was completed during the Resident Quality Inspection

During the course of the inspection, the inspector(s) spoke with the Administrator, the Maintenance Supervisor, the Rehabilitation Manager, the Activation Manager, the Nutrition Manager, eight Personal Support Workers(PSW), five Registered Practical Nurses(RPN), six Registered Nurses(RN) and three Dietary Aids, forty residents, the President of the Resident Council and the President of the Family Council as well as observing a meal service, a medication pass, general and specific resident care, reviewed one critical incident report, forty resident clinical records and the policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

11 WN(s)
4 VPC(s)
2 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

Findings/Faits saillants :

1. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A resident has a medically adaptive device that was not used in the way that was described in the written plan of care.

The Administrator and the Rehab Manager verified the care set out in the plan of care was to be provided to the residents as specified in the plan. S.6(7) [s. 6.]

2. When the plan of care was revised because care set out in the plan was not effective, the licensee failed to ensure that different approaches were considered in the revision of the plan of care.

A resident has an ongoing medical issue that staff members have attempted to address in the past however there was no ongoing follow up or new interventions attempted to address this medical issue.

One Nurse Manager and the Administrator verified that when the plan of care was revised because care set out in the plan was not effective, the staff needed to ensure that different approaches were considered in the revision of the plan of care. S.6.(11)(b) [s. 6.]

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

A resident requires a medical device to be used daily for their care.
The written plan of care does not describe his device or the care this device requires.

The Charge RN confirmed this resident did not have a written plan of care in place that sets out clear directions to staff and others who provide care to this resident.

4. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A resident has an ongoing medical issue that was noted and documented by staff members in the electronic record of the home. Other staff members were not aware of this documentation and did not act on the information.

The Administrator and the Nurse Manager confirmed the expectation is that all staff involved in different aspects of a resident's care should collaborate with each other so their assessments are integrated, consistent and compliment each other. s.6(4)(a) [s. 6.]

5. The licensee failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provide direct care to the resident.

A resident has a medical condition that requires interventions that were set out in the plan of care.
Interviews with staff members indicated that these interventions did not occur.

The Administrator and Nurse Manager verified the resident's written care plan should set out clear directions to staff and others who provide direct care to the resident. S.6(1)(c) [s. 6.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home

was dealt with as follows:
1. The complaint was investigated and resolved where possible, and a response that complied with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleged harm or risk of harm to one or more residents, the investigation was commenced immediately.
2. For those complaints that could not be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint was provided within 10 business days of receipt of the complaint including the date by which the complainant could reasonably expect a resolution, and a follow-up response that complied with paragraph 3 was provided as soon as possible in the circumstances.
3. A response was made to the person who made the complaint, indicating, i. what the licensee did to resolve the complaint, or ii. that the licensee believed the complaint to be unfounded and the reasons for the belief.

A resident made a verbal complaint to a staff member that was not documented, investigated or addressed and the resident did not receive a response to the complaint.

The Administrator confirmed the expectation is that resident concerns should be investigated and addressed and that a response was provided to the resident with regard to the concern. . [s. 101.]

2. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or the operation of the home be investigated, resolved where possible and a response provided within 10 days of the receipt of the complaint.

A person made a complaint to a staff member and the complaint was documented and addressed however the complainant did not receive a response to their complaint within 10 days.

The Administrator confirmed that the expectation is that family member receive responses to their complaints within 10 days. [s. 101.]

3. The licensee failed to ensure that a documented record is kept in the home that includes the nature of the complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow up actions required, the final resolution, if any, every date the on which any response was provided to the complainant and a description of the

response and any response made by the complainant.

A person made a verbal complaint to a staff member. The concern was addressed and resolved however there was no documentation of the complaint or resolution.

The Administrator confirmed the expectation is that any written or verbal complaint should be documented including the nature of the complaint, the date the complaint was received, the actions taken to resolve the complaint and the response to the complainant. [s. 101.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that food and fluids were served at a temperature that was both safe and palatable to the residents.

During the Resident Quality Inspection four residents reported that foods that were supposed to be served hot were served cold which made them not palatable.

The Nutrition Manager verified food and fluids should be served to the residents at a temperature that was both safe and palatable at all times. [s. 73. (1) 6.]

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 food and fluids are being served at a temperature that is both safe and palatable to the residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the advice of the Family Council was sought in developing and carrying out the satisfaction survey, and in acting on its results.

Richmond Terrace Long Term Care Home(LTCH) has an established Family Council.

The Administrator confirmed the licensee provided a satisfaction survey to the residents in 2014.
The Administrator reported the licensee did not seek the advice of the Family Council in developing and carrying out the satisfaction survey for 2014. [s. 85. (3)]

2. The licensee failed to ensure that the advice of the Residents' Council was sought in developing and carrying out the satisfaction survey, and in acting on its results.

Interview with the President of Resident Council, the Administrator and the Activation Manager revealed the licensee did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey.

The Administrator verified the expectation was that the home seek the advice of the Resident' Council in developing and carrying out the satisfaction survey, and in acting on its results. [s. 85. (3)]

3. The licensee failed to ensure that the results of the satisfaction survey were documented and made available to the Family Council, to seek their advice under subsection(3).

Richmond Terrace LTCH confirmed a Family Council is established in the home.
The Administrator reported the home has not yet released the results of the satisfaction survey for 2014.
The Administrator confirmed the LTCH completed a satisfaction survey in 2013.

The Administrator confirmed the LTCH did not provide the 2013 satisfaction survey results to the family council. [s. 85. (4) (a)]

4. The licensee failed to ensure that the results of the satisfaction survey were documented and made available to the Residents' Council, to seek their advice under subsection(3).

Interviews with the President of Residents' Council, the Activities Manager and the Administrator revealed the licensee did not document and make available to the Residents' Council the results of the satisfaction survey in order to seek out the advice of the Council about the survey from January 1 to December 31, 2014.

The Administrator verified the results of the satisfaction survey should be documented

and made available to the Residents' Council in order to seek the advice of the council about the survey yearly. [s. 85. (4) (a)]

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 the licensee seeks advice from the Resident's Council and Family Council, if any in developing and carrying out of the survey, and in acting on its results and that the results of the survey are documented and made available to the resident's council and the family council, if any, to seek their advice under subsection (3), to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 122. Purchasing and handling of drugs

Specifically failed to comply with the following:

s. 122. (1) Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug,
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and O. Reg. 79/10, s. 122 (1).
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug was acquired, received or stored by or in the home unless the drug:

(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply, and
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario

An audit of a medication cart on the second floor was conducted as part of the RQI with the Inspector and the Medication Nurse present. An unlabelled over the counter medication was noted in the cart.

This was confirmed by a Registered Nurse during observation and the Administrator after this observation. [s. 122. (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 no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131(7) unless the drug,
a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123;and
b)has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that it complied with manufacturer's instructions for the storage of the drugs specifically in relation to expiry dates.

An audit of a medication cart on second floor was conducted as part of the RQI with the Inspector and the Medication Nurse present. A blister pack of expired medication was found in the medication cart.

This was confirmed by the medication nurse. [s. 129. (1) (a)]

2. The licensee failed to ensure that all controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

An audit of a medication cart on the second floor was conducted as part of the RQI with the Inspector and the Medication Nurse (Registered Staff member) present.
A blister pack of a controlled medication was found in the unlocked portion of the medication cart and another controlled medication was found in the unlocked emergency drug box in the drug storage cupboard.

The Charge RN on duty confirmed that all controlled substances should be stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. [s. 129. (1) (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 to ensure that drugs are stored in an area or a medication cart that complies with manufacturer's instructions for the storage of the drugs and that controlled substances are stored in a separate, double-locked stationary cupboard in a locked area or in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #7: 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 failed to 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.

A resident was found to have a call bell not within their reach.

This was confirmed by a staff member.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure the use of a PASD under subsection (3) to assist a resident with a routine activity of living was included in a resident's plan of care only if all of the following were satisfied:
1. Alternatives to the use of a PASD were considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.
2. The use of the PASD was reasonable, in light of the resident's physical and mental condition and personal history, and was the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living.
3. The use of the PASD was approved by, i. a physician, ii. a registered nurse, iii. a registered practical nurse, iv. a member of the College of Occupational Therapists of Ontario, v. a member of the College of Physiotherapists of Ontario, or vi. any other person provided for in the regulations.
4. The use of the PASD was consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
5. The plan of care provided for everything required under subsection (5).

A resident was found using a medical device for which a consent should have been obtained.

The Rehabilitation Manager and Administrator verified that a consent had not been obtained and should be obtained for the use of a PASD under subsection (3) to assist a resident with a routine activity of living. [s. 33. (4) 4.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, be reassessed at least weekly by a member of the registered nursing staff.

A resident who had alterations in the integrity of their skin did not have their wounds assessed by a Registered staff member on a weekly basis using a clinically appropriate wound assessment tool.

The Administrator confirmed that the expectation is that all wounds are monitored by a Registered staff member on a weekly basis with a clinically appropriate wound assessment tool. [s. 50. (2) (b) (iv)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

A resident reported to the Resident Council that there was an issue with food temperatures and there was no follow up or written response provided to this resident or the Resident Council.

The Administrator and the Nutrition Manager verified the president of Resident Council should have received a response in writing within 10 days of the reporting of a concern or recommendation. [s. 57. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program.

During observation of a resident's room an unlabelled resident specific medical device was found on the floor in an unclean manner.

The Administrator confirmed that it is the expectation that all staff participate in the implementation of the infection prevention and control program. [s. 229. (4)]

Issued on this 6th day of February, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ALISON FALKINGHAM (518), PATRICIA VENTURA (517), ROCHELLE SPICER (516)
Inspection No. / No de l'inspection :	2015_257518_0001
Log No. / Registre no:	L-001654-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 29, Feb 4, 6, 2015
Licensee / Titulaire de permis :	RICHMOND TERRACE LIMITED 284 CENTRAL AVENUE, LONDON, ON, N6B-2C8
LTC Home / Foyer de SLD :	RICHMOND TERRACE 89 RANKIN AVENUE, AMHERSTBURG, ON, N9V-1E7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LAURA SCOTT

To RICHMOND TERRACE LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Order / Ordre :

The licensee must ensure that there is a written plan of care that sets out clear directions to staff and others who provide direct care to the resident. LTCHA, 2007, S.O. 2007 c.8, s.6(1)(c)

The licensee must ensure that staff and others involved in different aspect of care to the resident collaborate with each other in the assessment of the resident so their assessments are integrated and are consistent with and compliment each other. LTCHA, 2007, S.O. 2007, c.8, s.6(4)(a)

The licensee must ensure that the care set out in the plan of care is provided to the resident as specified. LTCHA, 2007, S.O. 2007, c.8, s.6(7)

The licensee must ensure that when a resident is reassessed and the plan of care revised because the plan of care has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. LTCHA, 2007, S.O. 2007, c.8, s.6(11)(b)

Grounds / Motifs :

1. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A resident has an ongoing medical concern that was noted and documented by staff members in the electronic records of the home. Other staff members were not aware of this documentation and did not act on the information.

The Administrator and the nurse Manager confirmed the expectation is that all staff involved in different aspects of a resident's care should collaborate with

each other so their assessments are integrated, consistent and compliment each other. s.6(4)(a)

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

The written plan of care for a resident describes interventions that should occur however interviews with staff confirm these interventions did not occur.

The Administrator and Nurse Manager verified the resident's written care plan should set out clear directions to staff and others who provide direct care to the resident. S.6(1)(c)

The licensee did not ensure that care set out in the plan of care was provided to the resident as specified in the plan.

A resident has a medically adaptive device that was not used in the way that was described in the plan of care.

The Administrator and the Rehabilitation Manager verified the care set out in the plan of care was to be provided as specified in the plan.s.6(7)

When a plan of care was revised because care set out in the plan was not effective, the licensee failed to ensure that different approaches were considered in the revision of the plan of care.

A resident has an ongoing medical issue that staff members have attempted to address in the past however there was no ongoing follow up or new interventions attempted to address this medial issue.

One Nurse Manager and the Administrator verified that when the plan of care was revised because the care set out in the plan was not effective, the staff needed to ensure that different approaches were considered in the revision of the plan of care s.6.(11)(b)

(517)

2. The licensee did not ensure that the care set out in the plan of care was

provide to the resident as specified in the plan.

A resident requires a medical device to be used daily for their care.
The written plan of care does not describe this device or the care that this device requires.

The Charge RN confirmed this resident did not have a written plan of care in place that set out clear directions to staff and others who provide direct care to the resident.

(516)

3. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A review of resident #002's most recent written plan of care indicated the resident was not to use the tilt function on the tilt wheelchair and the resident was to use two 1/2 length side rails while in bed.
On Jan 6, 2015 the inspector observed the resident sitting in the wheelchair while
tilted and on January 13, 2015 the resident was observed lying in bed with two ¼ length rails up.
On Jan 12, 2015 three Personal Support Workers reported the resident regularly used the tilt
function on her wheelchair for positioning and comfort.
The Rehab Manager confirmed the resident was not to use the tilt function on her wheelchair.
The Administrator and the Rehab Manager verified the care set out in the plan of care was to be provided to the residents as specified in the plan. S.6(7)

(517)

4. When the plan of care was revised because care set out in the plan was not effective, the licensee failed to ensure that different approaches were considered

in the revision of the plan of care.

A review of resident #002's health care record revealed that interventions to address sleeplessness were initiated over 2 years ago on November 7, 2012. During the resident's Quarterly Summary on November 9, 2014 the resident's sleep was assessed and a Registered staff member documented the resident continued to sleep poorly throughout the night on a regular basis.
Interviews with three Personal Support Workers and three Registered Staff members revealed the resident continued to sleep poorly throughout the night on a regular basis as far back as 2012 and while in bed not sleeping was exhibiting anxious behaviours.
There were no different approaches considered in the revision of the plan of care or listed in
the resident's written plan of care to address the resident's difficulty sleeping following the
assessment findings of November 9, 2014.
One Nurse Manager and the Administrator verified that when the plan of care was revised because care set out in the plan was not effective, the staff needed to ensure that different approaches were considered in the revision of the plan of care. S.6.(11)(b)
(517)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 02, 2015

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 101. Dealing with complaints

Order / Ordre :

The licensee shall ensure that:
1) Every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents the investigation will commence immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. A response shall be made to the person who mad the complaint, including:
i) what the licensee has done to resolve the complaint, or
ii) that the licensee believes the complaint to be unfounded and thee reasons for the belief.

2) The licensee shall ensure that a documented record is kept in the home that includes,
a) the nature of each written complaint;
b) the date the complaint was received;
c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow up action required;
d) the final resolution, if any;
e) every date on which any response was provided to the complainant and a description of the response; and
f) any responses made in turn by the complainant.

Grounds / Motifs :

1. The licensee failed to ensure that a documented record is kept in the home that includes the nature of the complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow up actions required, the final resolution, if any, every date the on which any response was provided to the complainant and a description of the response and any response made by the complainant.

A person made a complaint to a staff member and the complaint was addressed however the complaint was not documented and the complainant was not given a response to the complaint.

The Administrator confirmed the expectation is that any written or verbal complaint should be documented including the nature of the complaint, the date the complaint was received, the actions taken to resolve the complaint and the response to the complainant. (518)

2. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or the operation of the home be investigated, resolved where possible and a response provided within 10 days of the receipt of the complaint.

A person made a complaint to a staff member and the complaint was documented and addressed however the complainant did not receive a response to their complaint within 10 days.

The Administrator confirmed that the expectation is that family member receive responses to their complaints within 10 days. (518)

3. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or the operation of the home be investigated, resolved where possible and a response provided within 10 days of the receipt of the complaint.

A resident made a complaint to a staff member and the complaint was not documented, addressed or investigated and no reply was provided to the resident.

The Administrator confirmed the expectation is that resident concerns should be investigated and addressed and that a response was provided to the resident with regard to the concern. (517)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 02, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 29th day of January, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Alison Falkingham

Service Area Office /
Bureau régional de services : London Service Area Office