Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 8, 12, 13, 14, 15, 2012	2012_029134_0013	Complaint

Licensee/Titulaire de permis

THE GOVERNING COUNCIL OF THE SALVATION ARMY
2 OVERLEA BLVD., TORONTO, ON, M4H-1P4

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

THE SALVATION ARMY OTTAWA GRACE MANOR
1156 WELLINGTON STREET, OTTAWA, ON, K1Y-2Z3

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

COLETTE ASSELIN (134)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Nursing, Registered Nurse, (RN), two Registered Practical Nurses (RPN), several PSWs, Resident # 1 and Resident # 3.

During the course of this inspection, the inspector conducted 3 complaint inspections, log # O-000823-12, O-000804-12 and O-000943-12.

During the course of the inspection, the inspector(s) reviewed the Continence and Bowel Program policy # E16, the Zero tolerance of Abuse and Neglect policy # A11 and the identified resident's health records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dignity, Choice and Privacy

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

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.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The Licensee failed to comply with section 3 (1) 1 and 4 of the LTCHA 2007, in that Resident # 3's rights were not fully respected and promoted and not cared for in a manner consistent with the resident's needs.

The plan of care for Resident # 3 was reviewed and there is an entry specifying that the resident requires constant supervision while toileted.

One day in April, 2012, Resident # 3 was placed onto the toilet at 14:55h and left unattended by the day PSW, who failed to notify the evening staff that Resident # 3 was on the toilet. At 15:10h a family member requested help from another PSW, who replied he/she was too busy and who proceeded to the bathroom to turn off the resident's call bell.

The resident's family member then asked the RPN for help who then replied "we're busy" and proceeded to call the Registered Nurse (RN) to come to the unit. When the RN entered Resident # 3's bedroom the bathroom door was open and the SDM saw Resident # 3 hanging from a lift by the arms, with the clothing around the resident's neck, the resident's chest was exposed and the resident's feet were dangling off the floor. The resident was then transferred in a wheelchair by the PSW and the RPN. The SDM reported that they left the resident without making sure the resident was properly seated with clothes adjusted. When SDM asked the RN for assistance to transfer the resident into the chair, the RN left the room and did not come back to assist with the resident's transfer into a regular chair.

The SDM reported that on May 9, 2012, a PSW left Resident # 3 unattended on the toilet. The plan of care was reviewed and there is an entry specifying that the resident requires constant supervision while toileted. The PSW was interviewed on June 8, 2012 at 16:45 by the inspector as it relates to Resident # 3's identified need for constant supervision while on the toilet. The PSW indicated that even though Resident # 3's care plan specifies constant supervision while toileted, staff does not usually stay by the resident in the bathroom.

Resident # 3 was interviewed by inspector # 134 June 8, 2012 and indicated that staff is not rough, "they just want it done, they work fast". Resident # 3 reported that the PSW normally stay in the bathroom when toileted. "They don't leave me there alone very often".

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2. The Licensee has failed to comply with section 3 (1) 8, in that the licensee did not fully respect and promote Resident # 1's right to be afforded privacy in treatment and in caring for personal needs.

Resident # 1 is capable and knowledgeable about his/her medical condition. The resident's plan of care requires bladder and bowel treatment in bed. The resident feels this practice is humiliating and embarassing. The Resident reported to the inspector that even though the bedroom door is closed and that there is a sign on the door, asking staff "not to come in when door closed", staff will knock and immediately come in while treatment is in process. The resident expressed being very upset and humiliated when privacy is not respected during treatments.

Three staff members were interviewed by the inspector and they indicated that they do enter the room during treatment if they need to speak to the nurse, while the resident is having treatments done. One PSW indicated that Resident # 1 cries when privacy is not respected, that even though a sign is placed on the bedroom to remind staff not to enter, staff still knock and go in.

Resident # 1 reported that on one day in April, 2012 one RPN proceeded to provide bowel treatment while he/she was on the shower chair in the shower room. The resident reported that the procedure was humiliating and uncalled for, that privacy was not provided and expressed that the experience was extremely humiliating and embarrassing.

The Licensee failed to consider the Resident's need for privacy in treatment and in caring for personal needs.

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 every resident's rights are fully respected and promoted, in that every resident is treated with courtesy and respect in a way that fully recognizes his/her individuality and dignity and that every resident is cared for in a manner consistent with his/her needs. This corrective action shall include training of all staff on the Residents' Bill of Rights, to be implemented voluntarily.

WN #2: 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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The Licensee failed to comply with section 6 (1) (c) and (11) (a) & (b) of the LTCHA 2007, in that it failed to provide clear direction to staff: failed to ensure that Resident # 1 be given the opportunity to participate fully in the development and implementation of the plan of care.

Resident # 1's care plan, printed June 12, 2012, was reviewed. There is an entry that specifies that Resident #1 is to be toileted for bowel movements only.

Resident # 1 was interviewed and reported that due to a change of staff in April 2012, the toileting regime was changed without the resident's consent. The resident reported that daily toileting is no longer part of the plan of care and that is very upsetting. The resident indicated the preference would be to be toileted daily, using the Tempo lift, as done since admission of March 2010 to April 2012. The Resident reported that the Registered Staff are directed to provide bowel treatment in bed and expressed the procedure to be humiliating and undignified.

Resident # 1's care plan was reviewed and there is no clear direction as it relates to the resident's bowel routine and procedure.

Resident # 1 was interviewed June 8, 2012 by the inspector and insisted that the bowel procedure staff claim to have been doing is not exactly how it was done. The resident reported there is confusion over the type of procedure and treatment needed related to the resident's condition. The resident reported to the inspector that even though a complaint was voiced to management, no change was made to the plan of care. The resident is capable of making decisions and to participate fully in the development of the plan of care.

The RPN, who took care of Resident #1 for an extended period during the last two years, was interviewed by the inspector on June 12, 2012. The RPN reported how the bowel treatment was done and explained how effective it was at the time. The RPN reported this procedure was carried out for two years without any problems or negative side effects and reported that the bladder treatment was also done once a shift without difficulty or negative outcomes. The RPN indicated the bowel treatment took only a few minutes as the resident responded well to the procedure.

Resident # 1 reported there were no reported injury following any bladder treatment done over the toilet while sitting in a transfer sling. The resident also indicated there were no negative effects reported from having the preferred bowel treatment done over the toilet and indicated the procedure was more acceptable as it felt more normal and dignified than having the procedure done in bed.

The licensee failed to give Resident # 1 an opportunity to fully participate in the development and implementation of the plan of care and failed to consider the resident's preferences in bowel and bladder treatment, when applying modifications with respect to the revision of the the plan of care.

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 plan of care provides clear direction to staff as it relates to Resident # 1's bowel and bladder elimination treatments and procedures, and that Resident # 1 be given the opportunity to participate fully in the development and implementation of the plan of care, to be implemented voluntarily.

Issued on this 15th day of June, 2012

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

Colette Asselin, LTCH Inspector #134