Ontario

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

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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
Oct 24, 25, 29, 30, 2012	2012_198117_0004	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

LYNE DUCHESNE (117), AMANDA NIXON (148)

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 Executive Director, Director of Care (DOC), Food Service Supervisor (FSS), Registered Dietitian, several Registered Nurses (RN), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), a housekeeper, a food service worker and with several residents.

During the course of the inspection, the inspector(s) reviewed the health care records of several residents, observed resident care and services, observed breakfast meal service on October 24, 2012, reviewed the home's 24-Hour Nursing Report Book, reviewed the home's complaint process and current complaint file, reviewed the home's policy #E16 titled " Continence Care and Bowel Management Program", observed dining room and servery on Queen and Parkdale Units and reviewed a Critical Incident Report.

This inspection occured on-site October 24 and 25, 2012. Two complaint inspections were conducted log # O-002137-12 and # O-001775-12.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Continence Care and Bowel Management

Critical Incident Response

Dining Observation

Nutrition and Hydration

Reporting and Complaints

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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding.

2. An unexpected or sudden death, including a death resulting from an accident or suicide.

3. A resident who is missing for three hours or more.

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

1. 1. The licensee failed to comply with the O.Reg 79/10 s. 107 (1) in that an outbreak of a reportable disease or communicable disease, as defined in the Health Protection and Promotion Act, was not immediately reported to the Director.

On October 22, 2012, an Influenza A outbreak was declared on a resident care unit. The unit RN and DOC confirmed to inspector #117 on October 24, 2012 that the home did have an outbreak of a reportable / communicable disease. A Critical Incident report regarding the outbreak was submitted to the Director on October 25, 2012, three days after the outbreak was declared within the home. The home did not immediately report the onset of an outbreak to the Director.

2. The licensee failed to comply with O.Reg 79/10 s. 107 (5) in that the home did not ensure that the resident's Substitute Decision Maker, if any, or any person designated by the substitute decision maker and any other person designated by the resident are promptly notified of any serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified.

In July 2012, Resident #2's Power of Attorney (POA) had left instructions with the home on how to contact him/her and another family member during POA's holidays, if there was any change in the resident's health status. On October 24, 2012, this information was confirmed with the unit's regular registered nursing staff #S103 and #S104.

On a specified day in July 2012, two registered staff members #S109 and #S110 did not contact the POA when Resident #2 had a change in health status. Progress notes indicate that #S109 left a voice mail message on POA's home number one day after the resident's change in health status and did not contact any other family member until two days after a change in the resident's health status.

The POA was not contacted in a timely manner, via communicated contact information, related to resident #2's change in health condition. (#O-001775-12)

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

Specifically failed to comply with the following subsections:

s. 101. (1) Every licensee shall 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 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 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced 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 made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

The licensee failed to comply with O.Reg. 79/10 s.101(1)1 in that a written complaint made to the home concerning the care of a resident and operation of the home was not responded to within 10 business days.

Resident #1 reported that a recently submitted written complaint was made to the home but that a response from the home was yet to be received. A review of the home's files demonstrated a written complaint was received from Resident #1 in August 2012, regarding the food quality. The home was unable to provide evidence that any response was made to Resident #1 concerning this complaint. (#O-002137-12) (148)

2. The licensee failed to comply with O.Reg. 79/10 s.101(1)(3) in that the response to a written complaint made to the home concerning the care of a resident and operation of the home did not indicate what the licensee has done to resolve the complaint or that the licensee believes the complaint to be unfounded.

Resident #1 reported that a recently submitted written complaint was made to the home but that a response from the home was yet to be received. A review of the home's files demonstrated a written complaint from Resident #1 was received on a specified date in August 2012 regarding staff identification, hand hygiene, food quality and dining service. A response was provided to Resident #1 on a specified day in September 2012 regarding issues related to staff identification and hand hygiene. The home did not provide response to concerns related to food quality and dining service. (#O-002137-12) (148)

3. The licensee failed to comply with O.Reg. 79/10 s. 101(2) in that no documented record is kept as described in this regulation.

A review of the home's files demonstrated that there is no process to ensure that there is a documented record of verbal complaints including the nature of the complaint, date complaint received, action taken, any resolution, date and description of response and any response by the complainant, as per O.Reg. 79/10 s.101(2).

Interview of Executive Director and DOC on October 24, 2012 stated that the home documents most verbal complaints within the resident health care record. Other verbal complaints may be documented in managers notes. There is no clear documented record of both verbal and written complaints as set out in O. Reg. 79/10 s. 101(2). (#O-002137)

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following subsections:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA s. 15 (2) (a) as it relates to the home's furnishings and equipment are not kept clean and sanitary.

On October 24, 2012, at 14:20, it was observed that 6 / 7 dining room tables on Queen's Resident Home Area have dried food debris along the edges of dining tables. It was also noted in the Queen's dining room servery, that the Garland stove exterior was soiled with dried food debris on the outside surface and door handle.

On October 25, 2012 at 10:30 am, it was observed that the same 6 tables and servery stove still had dried food debris on them.

The unit housekeeper #S105 and the home's Food Service Supervisor stated that there is no set individual or department currently responsible for ensure that various equipment in the dining rooms and serveries are deep cleaned on a regular basis.

WN #4: 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).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA s. 6 (1) (c) as the plan does not set out clear directions to staff and others who provide direct care to the resident.

The health care record of Resident #2 indicates that the resident had two episodes of change in health status in July and in August 2012. Interviewed PSWs #S106, #S107 and #S108 state that they do monitor the resident for any possible indication of change in health status when providing daily care to the resident. The resident's plan of care identifies that the resident can self toilet with some assistance and that he/she requires assistance with various aspects of daily care. However it does not identify the need to monitor the resident for a possible change in health status. (log # O-001775-12)

2. Interview of RPN #S100, on October 24, 2012 stated that the home provides Resident #1 with large briefs for day and night and that he/she is toileted with assistance when he/she rises in the morning, after breakfast and in the evening before bed.

Interview of PSW #S101, on October 24, 2012 stated that the home provides Resident #1 with toileting when he/she rises, after breakfast and usually after lunch.

Interview of PSW #S102, on October 24, 2012 stated that the home provides Resident #1 with toileting after breakfast or in the afternoon, not usually both. PSW #2 was observed to provide toileting to Resident #1 the morning of October 24, 2012 and PSW #S102 stated that the resident would not be toileted this afternoon since he/she was toileted this morning.

Interview of Resident #1 on October 24, 2012 stated that he/she is rarely toileted on a consistent basis and would like to be toileted at least twice each day.

A review of Flow Sheets for October 2012 indicates that Resident #1 does not require toileting. A review of the Plan of Care for toileting, last updated October 4, 2012, indicates that Resident #1 does not require toileting and uses his/her own products. (Log #O-002137-12)

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 in the the plan needs to set out clear directions to staff and others who provide direct care to the identified residents as it relates to continence care and bowel management, to be implemented voluntarily.

Issued on this 30th day of October, 2012

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

Lyne Duchesne