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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 21, 2017	2017_702197_0012	024733-17	Resident Quality Inspection

Licensee/Titulaire de permis

The Corporations of the United Counties of Leeds and Grenville, the City of Brockville, the Town of Gananoque and the Town of Prescott
c/o St. Lawrence Lodge 1803 County Road 2 BROCKVILLE ON K6V 5T1

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

ST. LAWRENCE LODGE
1803 County Road, #2 East Postal Bag #1130 BROCKVILLE ON K6V 5T1

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

JESSICA PATTISON (197), CATHI KERR (641)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 4-8, 11 (on-site), 12 (off-site), 2017

Four complaint inspections were completed concurrently with the Resident Quality Inspection:
Log 026099-17 - related to dealing with complaints, residents' bill of rights, skin and wound and plan of care
Log 027269-17 - related to skin and wound, medication administration, repositioning and nail care
Log 028795-17 - related to nail care, temperature in spa room, dining and activation
Log 028800-17 - related to care plan and infection control

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Assistant Directors of Care, the Manager of Environmental Services, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Family Council Chair, Residents' Council Chair, the Manager of Activation, housekeeping staff, Food Service Workers, activation staff, residents and residents' family members.

The inspectors also completed a tour of all resident areas, observed dining service and medication administration, observed resident care, reviewed resident health care records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **10 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The following finding is related to complaint log 027269-17:

The licensee has failed to comply with LTCHA 2007, s. 6(5) in that the SDM of a resident was not provided the opportunity to participate fully in the development and implementation of the resident's plan of care.

On a specified evening, resident #023 was noted by PSW staff to have a wound. PSW staff reported their observations to the registered nursing staff during that shift. RPN # 125 documented in the progress notes that the wound was treated but did not indicate that the resident's SDM was notified.

During a phone interview with ADOC #110, she stated that she spoke with both RPN #125 and RN #126 who worked on the shift when the wound was discovered and both indicated they had not notified resident #023's SDM.

The SDM of resident #023 indicated to the inspector that he/she had not been notified of the resident's wound. [s. 6. (5)]

2. The following finding is related to complaint log 028800-17:

The licensee has failed to comply with LTCHA 2007, s. 6(7) in that the care set out in a resident's plan of care was not provided to the resident as specified in the plan.

Resident #028's family member indicated to the inspector and the home that he/she would like the resident to have non-pharmacological interventions as much as possible for any discomfort, specifically hot packs. Resident #028 and their family member met with ADOC #117 at a specified time and asked that resident #028 be offered hot packs daily.

Upon review of the resident's current care plan, it was noted that on a specified date, the following interventions were added to the resident's care plan:
- Offer hot packs daily, as per Activation and PRN (has own pack family assists with).
- Provide non-pharmacological treatment for relief of pain/discomfort.

ADOC #117 indicated during an interview that she did recall meeting with the resident and their family member and did make these changes to the care plan. She further stated that the resident is a capable resident and could ask for hot packs when needed.

During an interview on December 11, 2017, the Activation Manager indicated that hot packs are provided by activation staff. She stated that each floor has 1 full-time and 1 part-time activation staff and so residents should be offered hot packs whenever activation staff are present on their particular floor. She did note that there is no activation staff in the building on Sundays and holidays and so residents would not be offered hot-packs on these days. The Activation Manager also stated that once a week, activation staff on each floor should be making a note in PointClickCare (PCC) to indicate how often hot packs were offered.

Inspector #197 reviewed notes in PCC from activation for a specified period and found one note related to hot packs for resident #028 that indicated he/she would benefit from hot packs 5-6 times per week.

Activation Aide #124 that works on resident #028's home area indicated that she usually keeps track of how often she offers hot packs with her own paper records. She provided these to the inspector and it was noted that resident #028 was not being offered hot packs on a daily basis.

Interview with Activation Aide #114 indicated that she did not keep records of how often she offered hot packs to resident #028, but she recalled offering them to him/her 3 times

in one particular week when Activation Aide #124 was on vacation.

Review of resident #028's Treatment Administration Record (TAR) for a specified period shows an order for hot packs PRN. There are no initials on the TAR to indicate the resident was given hot packs by registered staff.

Therefore, the resident is not being offered hot packs daily, as per the resident's current plan of care. [s. 6. (7)]

3. The following finding is related to complaint log 027269-17:

The licensee has failed to comply with LTCHA 2007, s. 6(9)1 in that the provision of care set out in the plan of care for resident #023 was not documented.

1. The current care plan for resident #023 indicates they are to be repositioned every 2 hours.

During an interview with ADOC #110, she indicated that repositioning is documented on the resident's flow sheets that PSW staff complete at the end of each shift.

Documentation of four one week periods was provided by ADOC#110. Upon review, it was noted that the repositioning of resident #023 was not documented on 42 shifts.

2. The home's procedure # 0401-03-18 Nail Care, last reviewed June 2017, indicates the following:

Procedure:
4. Trim fingernails minimally weekly with scissors or clippers,...
8. "Tick" off and sign flow sheet in appropriate column

During an interview with ADOC #110, she indicated the expectation for nail care for resident #023 would be that staff provide nail care on bath days, twice weekly, and any other time as needed.

Documentation of a four week period was reviewed for resident #023. Nail care was documented as being provided once during that time.

Resident #023's care related to repositioning and nail care were not documented as required. [s. 6. (9) 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 resident #023's substitute decision maker is provided the opportunity to participate fully in the development and implementation of the resident's plan of care, to ensure that care is provided as specified in the plan of care for resident #028 and that the provision of care related to nail care and repositioning is documented for resident #023, to be implemented voluntarily.

WN #2: 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 following finding is related to complaint log 027269-17:

The licensee has failed to comply with O. Reg. 79/10, s. 8(1)(b) in that the home did not comply with their skin and wound procedure.

O. Reg. 79/10, s. 48(1) states that every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the

home:
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

The home's procedure # 0401-05-43 Pressure Ulcer/Wound Treatment instructs registered staff to do the following:
2)The prescribed intervention will be documented on the TAR (treatment administration record) record and and Nursing Care Plan initiated. The Nursing Care Plan should specify affected area(s) and pertinent interventions.
5)Routine treatment interventions/dressing changes will be initialed on the TAR record
9)For stage II, III, IV and X wounds, the Registered Staff will document a twice-weekly assessment Monday & Thursday on the Pressure Ulcer/Wound Assessment Table.

On a specified shift, PSW staff discovered that resident #023 had a wound and reported it to the registered nursing staff on that shift. RPN #125 documented in the progress notes that the area was treated as per RN direction. She also indicated that the resident was added to next physician's round for assessment.

Documentation of the wound and treatment was as follows:

Three days after the wound was discovered, the progress notes indicate that resident #023's wound was assessed by the physician and specific instructions given.

Four days after the physician assessment RPN #120 made a progress note indicating the wound was draining and that a treatment was completed.

One week after RPN #120's progress note, RPN #112 documented a wound assessment that indicated the stage of the resident's wound and that RD and RN made aware.

Resident #023's current care plan was reviewed and there was nothing to indicate the resident had altered skin integrity and/or what interventions were in place to treat/prevent further skin breakdown.

Resident #023's Treatment Administration Record was reviewed and there were three treatments related to altered skin integrity/wounds present. For each of the three treatments, there were multiple times when they were not signed as being completed.

Upon review of the Pressure Ulcer/Wound Assessment Tool, it indicates that staff are to

complete weekly assessments for all pressure ulcers/wounds. Since the wound was discovered on a specified date, there was only one documented assessment which was completed two weeks after the wound was discovered.

During a phone interview with ADOC #110, she indicated that she would have expected staff to start doing weekly assessments as soon as the wound was discovered.

Therefore, steps 2, 5 and 9 of the home's Pressure Ulcer/Wound Treatment procedure were not complied with. [s. 8. (1) (a),s. 8. (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 the home complies with their skin and wound procedures for resident #023, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that medications were given to residents #026, #019 and #011 in accordance with directions for use specified by the prescriber.

On a specified date, resident #026 was given the wrong dose of a medication on four different occasions. During an interview, ADOC #117 indicated that she had investigated the medication incidents related to resident #026 and agreed that resident #026 did not receive the proper dose of medication at four different times during that day.

On a specified date, resident #019 was given the wrong dose of a particular medication. During an interview, ADOC #113 acknowledged that resident #019 had received the wrong dose of medication on that day and stated she had completed an investigation into the incident.

On a specified date, resident #011 was given the wrong dose of a particular medication. During an interview, ADOC #117 indicated that resident #011 had received the wrong dose of medication and that she had conducted an investigation into the incident.

The licensee failed to ensure drugs were administered to resident #026, #019 and #011 in accordance with directions for use specified by the prescriber. [s. 131. (2)]

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 medications are given to residents in accordance with directions for use specified by the prescriber, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident or the resident's Substitute Decision Maker (SDM) if any for residents #011, 019 and 026.

On a specified date, resident #019 was given the wrong dose of a particular medication. Inspector #641 reviewed resident #019's health care record, including the medication incident report, progress notes and paper chart. There was no evidence of documentation that resident #019 had been monitored after the incident was noted and that either the resident or the resident's SDM was notified of this medication incident.

During an interview with Inspector #641 on December 7, 2017, the Assistant Director of Care, ADOC #113 indicated that she had completed an investigation into the incident involving resident #019. She indicated that when there was a medication incident, the family would be notified only if there was a concern with the resident. The ADOC specified that resident #019 should have had an assessment completed at the time of the incident and this would have been documented in the progress notes.

On a specified date, resident #011 was given the wrong dose of a particular medication. Inspector #641 reviewed resident #011's health care record, including the medication incident report, progress notes and paper chart. There was no evidence of documentation that resident #011 had been monitored following the medication incident and that either the resident or the resident's SDM was notified of this medication incident.

During an interview with Inspector #641 on December 11, 2017, ADOC #117 indicated that she had conducted an investigation into this incident. The ADOC indicated that the families were not always notified of an incident, depending on the outcome to the resident.

The licensee failed to ensure that after a medication incident, immediate actions were taken to assess and maintain the health of residents #019 and #011 and the incident reported to the resident or the resident's Substitute Decision Maker (SDM). [s. 135. (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 every medication incident involving a resident is documented, with a record of immediate actions taken to assess and maintain the resident's health and report each incident to the resident or the resident's substitute decision maker, to be implemented voluntarily.

WN #5: 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:

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; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(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 has failed to comply with LTCHA 2007 s. 15 (2)(a) in that the licensee did not ensure that a resident's wheelchair was kept clean and sanitary.

On a specified date, Inspector #197 noted a strong urine odour in resident #010's room. Interviews with housekeeping staff #104, RPN #105, PSW's #103 and #108 and ADOC #110 revealed that they had all noted a urine odour in the resident's room. Housekeeping staff #104, PSW #108 and ADOC #110 indicated that they felt the urine odour was coming from the resident's wheelchair.

ADOC # 110 and PSW # 108 told the inspector that resident wheelchairs are cleaned once per week by night staff and provided the schedule. Resident # 010's wheelchair was scheduled to have been cleaned on a particular day, but there was no signature to indicate it had been done. ADOC #110 indicated that if the sheet was not signed then it likely was not completed. The last time the resident's wheelchair was signed as being cleaned was the week prior.

During a follow-up interview with ADOC #110 on December 11, 2017, she indicated that the resident's wheelchair had since been cleaned and that they are looking at more frequent cleanings due to the resident's care needs.

During observation of the resident's room on December 11, 2017, with resident and wheelchair present, the strong urine odour was no longer detected. [s. 15. (2) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The following finding is related to complaint log # 028795-17:

The licensee has failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

Inspector #197 received a complaint from a family member indicating that one of the spa rooms on a particular unit had a vent that was blowing cold air directly onto residents. The family member indicated being concerned that his/her loved one may be refusing baths because this cold air is making the bathing process uncomfortable. The family member also indicated that this concern had been brought forward to the home before but was unsure if anything had been done to correct the issue.

During an interview with Inspector #641 on December 11, 2017, PSW #102 indicated that the spa/shower room was cool and that some of the residents had complained about the temperature. He indicated that there were vents in each area of the spa rooms that blow cold air down. PSW #102 showed Inspector #641 the vents in the spa room. On entering into the spa room, the vent was blowing cold air down, such that the Inspector was able to feel the difference in temperature on her face. The vent above the tub was also blowing cold air. Beside this vent was a red heat light that PSW #102 indicated they would turn on when the resident was in the room which helped to keep this room a little warmer.

Inspector #641 interviewed Environmental Manager #109 on December 11, 2017 and requested a temperature reading in the two areas of the particular spa room. The Environmental Manager indicated that at 1550 hours on December 11, 2017, with the assistance of a maintenance mechanic, they obtained two temperatures at the entrance of the spa room and two in the tub room. The temperature at the vent in the entrance way of the spa room was 20.7 degrees Celsius and by the drywall in the entrance way it was 21.4 degrees Celsius. The temperature in the vent above the tub was 20.6 degrees Celsius and near the drywall in the tub room was 20.8 degrees Celsius.
The Environmental Manager #109 also indicated that she and the maintenance mechanic took temperatures in the basement at the source of the heating system indicating that the supply temperature was 19.7 degrees Celsius and the return was 20.9 degrees Celsius.

The licensee failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius. [s. 21.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The following finding is related to complaint log #028795-17:

The licensee has failed to ensure that resident #027 received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

Inspector #197 met with resident #027 and the resident's family member on a specified date at approximately 1120 hours in the resident's room. During the conversation it was noted that the resident's finger and toenails were quite long (resident's family member removed resident's socks to show the inspector). The resident was not upset about his/her nails, but the family member indicated that due to a specific medical condition, he/she was concerned that the resident's toenails would get so long that the edges may puncture the resident's toes.

During an interview with Inspector #641 on December 11, 2017, the Director of Care indicated that the licensee's policy, Nail Care #0401-03-18, last reviewed June 2017, related to the cutting of toe nails for all residents with a specific health condition, specified that the registered staff were responsible for cutting their toenails every two weeks. The home had a designated RPN who came in weekly to specifically do the foot care for those residents. The DOC specified that this RPN, referred to as the foot care nurse, would document when she had completed foot care for a resident in a progress note on the residents chart. When informed by the Inspector that resident #027 had progress notes documenting that foot care was done once a month during a certain

period, and then no further documentation was noted, the DOC indicated that there was no expectation for the foot care nurse to follow the same time frame of having the resident's toenails cut every two weeks. The DOC indicated that when the policy was initiated in March of 1995, the home did not have a foot care nurse. Inspector #641 pointed out that the policy had just been reviewed in June of 2017. The DOC specified that the foot care nurse would assess each resident and determine how often that resident required their toenails trimmed.

The licensee failed to ensure that resident #027 received preventive and basic foot care services. [s. 35. (1)]

2. The following finding is related to complaint log #028795-17:

The licensee has failed to ensure that resident #027 received fingernail care, including the cutting of fingernails.

Inspector #197 met with resident #027 and family member on a specified date at approximately 1120 hours in the resident's room. During the conversation it was noted that the resident's finger and toenails were quite long (resident's family member removed resident's socks to show the inspector). The resident was not upset about his/her nails, but the family member indicated that since the resident has a specific medical condition, there was concern about the nails getting too long.

During an interview with Inspector #641, PSW #102 indicated that the PSW's did fingernail care on all the residents at the time of their baths. PSW #102 specified that this would be documented on the flow sheet for each of the residents. Inspector #641 interviewed RPN #123, who indicated that residents received nail care by the PSW's on their bath days.

Inspector #641 reviewed the PSW's flow sheets for resident #027 for a two month period. On 2 days there was a notation on the day shift that the resident had done their nail care independently. There was no further documentation during that time frame that nail care had been done for this resident, indicating that during the first three weeks and last four weeks of the time period reviewed, resident #027 had not received nail care. On a specified date during the inspection period, Inspector #641 observed resident #027's fingernails to be long when speaking with the resident.

Inspector #641 reviewed the licensee's Nail Care policy #0401-03-18, review date: June

2017. On page 1 of the policy it states… "assess each residents' nails daily during dressing and weekly during bathing to identify potential problems." Further on page 1 of the same policy "Trim fingernails minimally weekly with scissors or clippers…" "Tick off and sign Flow Sheet in appropriate column."

The licensee failed to ensure that resident #027 received fingernail care, including the cutting of fingernails. [s. 35. (2)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA s. 60(2) in that the licensee has not responded in writing within 10 days of receiving Family Council advice related to concerns or recommendations about the operation of the home.

The Family Council Chair indicated when interviewed that the licensee does not respond in writing within 10 days of receiving advice from the council related to concerns or recommendations.

Upon review of the Family Council meeting minutes for a specified period, the following concerns/recommendations were noted:

- Temperature/Air Flow - family council concerned about air being blown onto residents' backs in dining room and wondered if air deflectors could be used. Noted that Administrator will look into further.
- Concerns about staff not wearing name tags and asking that white boards on each home area be used to communicate who is on current shift. Family council asked that the ADOC's follow-up on each floor.
- Concerns that announcements being made over PA system are not clear and Family Council recommended that announcements be made as loud as possible and that the announcer speak slowly.
- Family council requested that nurse manager be present at each meeting to speak to resident care issues.
- Air Conditioning - discussion of redirection of certain air conditioning vents. Minutes indicate options are being explored as it is an ongoing concern in dining room, activity rooms and common areas.
- Family council suggests having a manager do rounds and document that all residents are back in their rooms or elsewhere after meals since they feel residents are being left in the dining room after meals - particularly supper.
- Family council expressed concerns related to staff shortages and care not being provided
- Concerns about staff walking in to resident's rooms without announcing themselves first
- Concerns about new beds

During an interview with the Administrator, he indicated that he has not responded in writing to any advice related to concerns or recommendations brought forward at Family Council meetings. He indicated that his process has been to attend all family council meetings and address concerns verbally during the meetings. [s. 60. (2)]

WN #9: 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).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 85(3) in that the licensee did not seek the advice of the Residents' or Family Councils in developing and carrying out the satisfaction survey.

During the Family Council Chair interview and the Resident Council Chair interview, both representatives indicated that neither council's advice had been sought by the licensee related to the development and carrying out of the satisfaction survey.

The Administrator for the home was interviewed and indicated that their satisfaction survey was developed in 2013 and advice related to the survey from the Family and Residents' Council had not been sought by the licensee since that time. [s. 85. (3)]

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

Specifically failed to comply with the following:

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. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The following finding is related to complaint log #026099-17:

The licensee has 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 be investigated, resolved where possible, and response provided within 10 business days of the receipt of the complaint.

A complainant indicated to Inspector #641 that on more than one occasion, he/she had made verbal complaints to one of the managers in the home and had not received any responses back from them as to what the outcome of the home's investigations were.

During an interview with Inspector #641 on December 11, 2017, the Administrator indicated the he would follow up with any written concerns that were addressed to the home and any other concerns that a manager may bring forward to him. The Administrator specified that if a verbal complaint was addressed to the Director of Care or one of the Assistant Directors of Care, then they would be responsible for following up with that concern and getting back to the family with their findings. He indicated that he kept a log of the written complaints and files of his investigation. Inspector #641 reviewed the complaints log for 2017 and two incidents that involved the specified complainant during the year.

A meeting was held at the home on a specified date involving the complainant, a family member of resident #021, two representatives for the family and the Administrator, the DOC, ADOC #110, and the Activation Manager #118. The complainant brought forward in the meeting frustration with not hearing back from the home with the outcome of their investigations when issues were brought to management's attention. The written response to this meeting was dated 15 business days after the meeting. Identified in this letter was the complainants problems with communication and exchange of information, as well as her other concerns related to resident #021. The letter doesn't identify how these issues would be, or had been resolved or if they were unfounded.

The licensee has 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 be investigated, resolved where possible, and response provided within 10 business days of the receipt of the complaint. [s. 101. (1) 1.]

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

Issued on this 8th day of January, 2018

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

Original report signed by the inspector.