Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 6, 2013	2013_220111_0007	000179, 000193	Complaint

Licensee/Titulaire de permis

Glen Hill Terrace Christian Homes Inc.
200 Glen Hill Drive South, WHITBY, ON, L1N-9W2

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

STRATHAVEN LIFECARE CENTRE
264 King Street East, Bowmanville, ON, L1C-1P9

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 9 & 10, 2013

2 Complaints inspections were completed.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Environmental Manager, the Chaplain and one resident.

During the course of the inspection, the inspector(s) reviewed the health records of two residents, reviewed the home complaints, complaints policy, and staff schedules.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

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. 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).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(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; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. Related to log # 000193:
A complaint was received by the MOHLTC from discharged Resident #1 indicating a staff member had failed to provide appropriate care to the resident resulting in injury and pain to the resident.

Review of Resident #1 progress notes indicated the Chaplain had visited the resident who informed the Chaplain that inappropriate care was provided by an unqualified staff member. The Chaplain contacted the DOC to speak with the resident.

Interview of DOC indicated a daily discussion was held with Resident #1 prior to discharge. The DOC indicated the complaint from Resident #1 was not documented and there was no investigation into the complaint documented.

The licensee failed to ensure that a verbal complaint made to the licensee or a staff member concerning the care of a resident was investigated and a response provided to the complainant within 10 business days. [s. 101. (1) 1.]

2. Review of the homes complaints from 2011 to 2013 indicated:
-there were no complaints documented for Resident#1.

The licensee failed to ensure a documented record was kept in the home that included the nature of the complaint, the date the complaint was received and the type of action taken to resolved the complaint, the final resolution if any, and every date on which any response was provided to the complainant and any response made in turn by the complainant. [s. 101. (2)]

3. Interview of Administrator indicated the home previously tracked all complaints received on paper in the complaint binder and is now done electronically since 2013. The Administrator indicated the home does not review complaints for trends.

Review of the complaints from 2011 to 2013 indicated there was no indication of a review of complaints received for trends quarterly or annually.

The licensee failed to ensure that the documented record is reviewed and analyzed for trends at least quarterly, the results of the review and analysis are taken into account in determining improvements required int he home and a written record is kept of each review and improvement. [s. 101. (3)]

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 written or verbal complaint made to the licensee or a staff member concerning the care of a resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

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Specifically failed to comply with the following:

s. 107. (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 79/10, s. 107 (2).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. Related to log #000179:

A Critical Incident (CI) report was received on February 16, 2013 for equipment failure indicating one of the two elevators was out of service on February 16, 2013 at 07:00 hours. An amendment to the CI was submitted on February 21, 2013 indicating the elevator was repaired.

Interview of the Maintenance Manager indicated notification was received at approximately 22:30 hours on February 15, 2013 indicating one of the two elevators was not working and the elevator repair company was contacted. The Maintenance Manager indicated upon arrival at the home approximately 15 minutes later the elevator repair company had already arrived. The elevator repair company was unable to make the necessary repairs at that time, but was able to have the elevator repaired on February 19, 2013.

Interview of the DOC indicated one of the two elevators was not working on February 15, 2013 and was back up and running on February 17, 2013.

Review of the MOHLTC case notes for the month of February 2013 indicated no calls were received from the home or after hours regarding an elevator out of service.

The licensee failed to ensure the Director was notified immediately of an emergency, including the loss of essential services and when it is after normal business hours, the licensee shall make the report using the Ministry's after hours emergency contact. [s. 107. (2)]

2. The Critical Incident (CI) report received on February 16, 2013 for equipment failure was amended on February 21, 2013 by the DOC indicating the actions taken included "Extra PSW's were added to the day and evening shifts to accommodate the increased resident load on the one elevator".

Interview of the Maintenance Manager confirmed the Maintenance Manager was unaware of any extra staffing brought into the home to assist residents while the one elevator was not in service.

Review of the staffing schedule and call in records for the period of February 15-19, 2013 indicated no extra PSW staff were put in place while the elevator was not in

service.

Interview of the DOC indicated extra staff were not brought into the home while the one elevator was not in service.

The licensee failed to report what care was given or action was taken in response to the incident. [s. 107. (4) 3.]

3. The Critical Incident (CI) report received on February 16, 2013 for equipment failure indicated under analysis or follow-up long term action was "none at this time".

The licensee failed to ensure that an analysis and follow-up action was included related to prevent recurrence. [s. 107. (4) 4.]

Issued on this 6th day of June, 2013

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

[signature], #111