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 prévue le Loi de 2007 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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection/ Genre d'inspection
Oct 16, 2014;	2014_369153_0010 (A1)	T-1060-14	Critical Incident System

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF SIMCOE
1110 Highway 26, Midhurst, ON, L0L-1X0

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

SUNSET MANOR HOME FOR SENIOR CITIZENS
49 RAGLAN STREET, COLLINGWOOD, ON, L9Y-4X1

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

LYNN PARSONS (153) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Changes to Order #001 icluded:
1) revised date for submission of plan to October 24, 2014
2) revised date this order must be complied by Decemeber 19, 2014.

Issued on this 16 day of October 2014 (A1)

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

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 prévue le Loi de 2007 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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection/ Genre d'inspection
Oct 16, 2014;	2014_369153_0010 (A1)	T-1060-14	Critical Incident System

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF SIMCOE
1110 Highway 26, Midhurst, ON, L0L-1X0

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

SUNSET MANOR HOME FOR SENIOR CITIZENS
49 RAGLAN STREET, COLLINGWOOD, ON, L9Y-4X1

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

LYNN PARSONS (153) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 4, 5, and 10, 2014.

During the course of the inspection, the inspector(s) spoke with administrator, director of resident care (DOC), nurse manager, physician, registered nurses (RN), registered practical nurses (RPN), program and services supervisor, chaplain, life enrichment aide, personal support workers (PSW) and substitute decision maker (SDM).

During the course of the inspection, the inspector(s) reviewed resident clinical health records, staff statements, staff schedules, home internal investigation, staff training records and home policy and procedures related to responsive behaviours; completed observations of the incident location.

The following Inspection Protocols were used during this inspection:

Responsive Behaviours

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. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that different aspects of care are integrated and

are consistent with and complement each other.

A review of resident #1's medical diagnoses failed to identify specific medical conditions.

A review of the progress notes for resident #1 revealed comments related to the resident's dissatisfaction with life and a desire not to prolong life.
The comments included the following:
- a desire to die
- does not want to live anymore
- requesting a better sleeping pill to improve sleep.

The above comments were recorded on the 24 hour shift report but no action was taken to develop or implement a plan of care to respond to resident #1's expressed needs.
A review of the multi-disciplinary care conference dated March 27, 2014, indicated the resident continued to be dissatisfied with life in general.

A review of the pain assessment completed in July 2014, indicated the following behaviours:
- sad, pained worried facial expressions
- depressed mood.

Interviews with the physician and family indicated the resident became more dissatisfied with the quality of life as a result of the deterioration in resident #1's vision and hearing and the concern at the prospect of becoming dependent on others for the resident's care needs.

Despite the comments in the physician notes and changes to resident #1's drug regime to treat the mental health issues there was no collaboration with staff and others involved in the different aspects of care in the development and implementation of the plan of care so that different aspects of care were integrated and were consistent with and complement each other.

Interviews with staff provided conflicting information such as whether resident #1 exhibited signs and symptoms of a mental health illness.
Some staff interviewed perceived resident #1 as social, involved in activities and "out and about in the home". While other staff indicated resident #1 was unhappy with life and not not wanting to live any longer.

An interview with a program staff indicated that resident #1 attended and participated in many programs within the home. Upon review of participation records it became apparent that resident #1 had not met the established care plan goal to attend 3 to 4 programs each week in the summer months.
The program staff was surprised at the data collected on the participation records which indicated the resident had not been actively involved in the scheduled programs.

Resident #1 was found with vital signs absent.

An interview with the DOC confirmed there was no collaboration with staff and others involved in the different aspects of care in the development and implementation of the plan of care so that different aspects of care were integrated and were consistent with and complement each other. [s. 6. (4) (b)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that staff who provide direct care to residents, as a condition of continuing to have contact with residents, receive training related to mental health issues.
Interviews with nursing staff confirmed they had not received training on depression in the last year.
An interview with the DOC confirmed staff who provide direct care to residents had not received training on depression on an annual basis. [s. 76. (7) 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 all direct care staff receive training related to depression, to be implemented voluntarily.

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 prévue le Loi de 2007 les foyers de soins de longue durée

Issued on this 16 day of October 2014 (A1)

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

L. Parsons

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

Ministère 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

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : LYNN PARSONS (153) - (A1)

Inspection No. / No de l'inspection : 2014_369153_0010 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : T-1060-14 (A1)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Oct 16, 2014;(A1)

Licensee / Titulaire de permis : CORPORATION OF THE COUNTY OF SIMCOE
1110 Highway 26, Midhurst, ON, L0L-1X0

LTC Home / Foyer de SLD : SUNSET MANOR HOME FOR SENIOR CITIZENS
49 RAGLAN STREET, COLLINGWOOD, ON, L9Y-4X1

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

Ministère 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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : TOLLEEN PARKIN

To CORPORATION OF THE COUNTY OF SIMCOE, 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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

(A1)
The licensee shall prepare, submit and implement a plan for achieving compliance to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other but not limited to the following tasks:
1. Develop, implement and maintain a process to ensure there is a current record of each resident s medical diagnoses;
2. Develop an on-going process to assess, monitor and evaluate residents with depression that ensures the different aspects of care are integrated and consistent with and complement each other;
3. Develop and offer education on Depression to direct care staff.

The plan should include but not limited to:
- who will be responsible for completing all of the identified tasks and when the tasks will be completed

The plan is to be submitted via email to inspector-M.Lynn.Parsons@ontario.ca by October 24, 2014.

Grounds / Motifs :

1. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that different aspects of care are integrated and are consistent with and complement each other.

a) A review of resident #1's medical diagnoses failed to identify specific medical conditions.

b) A review of the progress notes for resident #1 revealed comments related to the resident's dissatisfaction with life and a desire not to prolong life.
The comments included the following:
- a desire to die
- does not want to live anymore
- requesting a better sleeping pill to improve sleep.

c) The above comments were recorded on the 24 hour shift report but no action was taken to develop or implement a plan of care to respond to resident #1's expressed needs.
A review of the multi-disciplinary care conference in March 2014, indicated the resident continued to be dissatisfied with life in general.

d) A review of the pain assessment completed in July 2014, indicated the following behaviours:
- sad, pained worried facial expressions
- depressed mood.

e) Interviews with the physician and family indicated the resident became more dissatisfied with the quality of life as a result of the deterioration in resident #1's vision and hearing and the concern at the prospect of becoming dependent on others for the resident's care needs.

f) Despite the comments in the physician notes and changes to resident #1's drug regime to treat the mental health issues, there was no collaboration with staff and others involved in the different aspects of care in the development and implementation of the plan of care so that different aspects of care were integrated and were consistent with and complement each other.

e) Interviews with staff provided conflicting information such as whether resident #1 exhibited signs and symptoms of mental illness.
Some staff interviewed perceived resident #1 as social, involved in activities and "out and about in the home". While other staff indicated resident #1 was unhappy with life and not not wanting to live any longer.

f) An interview with a program staff indicated that resident #1 attended and participated in many programs within the home. Upon review of participation records it became apparent that resident #1 had not met the established care plan goal to attend 3 to 4 programs each week in the summer months.
The program staff was surprised at the data collected on the participation records which indicated the resident had not been actively involved in the scheduled programs.

Resident #1 was found with vital signs absent.

An interview with the DOC confirmed there was no collaboration with staff and others involved in the different aspects of care in the development and implementation of the plan of care so that different aspects of care were integrated and were consistent with and complement each other. (153)

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

Dec 19, 2014(A1)

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

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

Ministère 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

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
Toronto ON M5S 2B1
Télécopieur : 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
Toronto ON M5S 2B1
Télécopieur : 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 16 day of October 2014 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNN PARSONS

Service Area Office /
Bureau régional de services : Toronto