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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 10, 2017	2017_639607_0007	005956-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

THORNTONVIEW
186 THORNTON ROAD SOUTH OSHAWA ON L1J 5Y2

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

JULIET MANDERSON-GRAY (607), CHANTAL LAFRENIERE (194), CRISTINA MONTOYA (461), JENNIFER BATTEN (672)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 18, 19, 20, 21, 24, 25, 26, 27 and 28, 2017.

During this Resident Quality Inspection, the following intakes were reviewed and inspected concurrently: Logs # 001161-17, 029220-16, 031623-16, 002044-16, 001504-17, 006499-17, 007632-17, 007922-17 and 007975-17.
Summary of Intakes:

1) 001161-17: Complaint, regarding medication management, insufficient staffing and resident to resident abuse;
2) 029220-16: Complaint, regarding staff to resident alleged neglect and house keeping;
3) 031623-16: Critical Incident Report, regarding an alleged resident to resident physical abuse;
4) 002044-16: Critical Incident Report, regarding an alleged resident to resident physical abuse;
5) 001504-17: Critical Incident Report, regarding an alleged resident to resident physical abuse;
6) 006499-17: Critical Incident Report, regarding an injury that resulted in transfer to hospital;
7) 007632-17: Complaint; regarding transfer and fall prevention;
8) 007922-17: Critical Incident Report, regarding an injury that resulted in transfer to hospital;
9) 007975-17: Complaint, regarding resident care

During the course of the inspection, the inspector(s) spoke with the Medical Director, a Physician, the Administrator, Director of Care (DOC), Assistant Director of Care (s) (ADOC), Environmental Service Manager (EVS), Programs Manager (PM), Registered Dietitian (RD), Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Office Personnel, Recreationist, Family Council Assistant, Co-Chair to Family Council, a Member of the Resident Council Team, Families and Residents.

During the course of the inspection, the Inspector(s), toured the long-term care home, observed staff to resident interactions, observed resident to resident interactions, reviewed clinical health records, meeting minutes of the Resident Council, annual staff retraining for 2015 and 2016, annual program evaluations for 2015 and 2016, home specific policies related to Fall Prevention and Injury Reduction, Safe Ambulation Lift and Transfer, Hazardous Substances,Resident Non-Abuse, Skin and Wound Care, Medications, Complaint Management, Resident Safety, Dementia Care and Maintenance Repair logs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **7 WN(s)**
- **3 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. (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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of resident #022 and #024, so that their assessments are integrated, consistent with and complement each other.

Re: Intake Log # 007922-17 for resident #024:

A Critical Incident Report (CIR) was submitted to the Director in April 2017, for an incident that caused an injury, for which resident #024 was taken to hospital. The CIR indicated that resident #024 was found in another resident's room sitting on the floor, and upon assessment, had indicated to a Registered Nurse that his/her body part was sore.

Resident #024 was admitted to the home on an identified date, with multiple diagnoses including Dementia.

A review of the plan of care, in place at the time of the incident, indicated the resident was independent with ambulation.

Review of resident #024's progress notes by Inspector #607, indicated that resident #024 had a fall in April 2017, at an identified time. Registered Practical Nurse (RPN) #128 had

documented that a head to toe assessment was conducted on the resident, the resident complained of a pain to a body part and was refusing to weight bear. The RPN also documented, the Physician was informed of the resident's fall and had indicated to the RPN that the resident was to be transferred to hospital for further assessments. In addition, RPN #128 documented that he/she contacted resident #024's Substitute Decision Maker (SDM) to inform him/her of the resident's status, and asked the SDM if he/she would have preferred the resident to stay at the home until further assessments were completed, or for the resident to be transferred to the hospital. RPN #128 further documented that the SDM indicated that it would be best for resident #024 to rest in bed until the portable laboratory assessment was completed the next day.

Interview with Physician #147 on an identified date April 2017, by Inspector #607, indicated that he/she became aware of resident #024 falling in April 2017, at which time, he/she had given RPN #128 instructions to contact resident #024's SDM to provide him/her with options of the resident being transferred to hospital, or have the portable laboratory company come in the next day to perform further assessments.

Interview with RPN #128 in April 2017, by Inspector #607, indicated that he/she informed Physician #147 of the resident's fall, and indicated the Physician had given him/her orders for medications, and had advised him/her to inform resident #024's SDM of the Physician's orders, and options for the resident to be transferred to hospital or have portable laboratory assessments completed the next day. The RPN indicated that the SDM informed him/her to have resident #024 wait for the next day to have portable laboratory assessments completed.

Interview with resident #024's Substitute Decision Maker (SDM) in April 2017, by Inspector #607, indicated that the RPN #128 informed him/her of the resident's fall, but there was no indication by staff of the extent of resident #024's injury, and further indicated that he/she was not given an option for the resident to be transferred to the hospital. The POA further indicated that he/she was informed by RPN #128 that a portable laboratory company will be coming to the home, the next day to complete further assessments, to which he/she agreed.

Further interview with resident #024's SDM in April 2017, by Inspector #607, indicated that between three identified date period, there were no communication from staff indicating that the portable laboratory assessment was not completed on an identified date in April 2017. The SDM indicated that it was not until four days later, he/she received a call from RPN #139 who indicated to him/her that the portable laboratory

company would not have been able to have an assessment completed to resident #024's body part, until an identified date in April 2017, which would have been seven days later. The SDM indicated he/she asked the RPN at the time, if resident #024 was getting up out bed and was told no. The SDM indicated he/she arrived at the home on an identified date in April 2017, and requested that resident #024 be sent to the hospital for further assessments to his/her body part, at which time, the resident was diagnosed with an injury to a body part.

Further review of the progress notes indicated that there were several incidents where RPN's #127, #139, #128 and #141 documented that resident #024 was having pain to a body part over three day time period in April 2017, and there was no documented evidence to indicate that the Physician was notified of the portable laboratory assessment ordered not being completed.

Further interview with Physician #147 in April 2017, by Inspector #607, indicated that there was no communication from staff to him/her, indicating that a portable laboratory assessment was not completed for resident #024's body part, over a four day time period. The Physician indicated that the expectation is for staff of the home to inform him/her if the ordered assessment was not completed during the ordered time frame, so that a decision could have been made to transfer resident #024 to the hospital.

During an interview with the Director of Care (DOC), by Inspector #607, in April 2017, the DOC indicated the expectation of the home is that staff should communicate to the Physician if an assessment was not completed during the ordered time frame.

2. Re: Intake Log #007632-17 related to resident #022:

A complaint was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date in April 2017, identifying multiple concerns, including concerns related to provision of care related to falls and transfers by staff involving resident #022.

A review of the assessment records for resident #022, indicated the resident had two falls, one on an identified date in January 2017, when the resident slid from a wheelchair during a transfer by staff using a sit to stand lift, and the second fall occurred in April 2017, when the resident slid from the edge of the bed during a transfer using sit to stand lift.

A review of the written care plan in place at the time of the fall, indicated that resident

#022 was at risk for falls related impaired mobility and had several fall interventions in place.

Further review of resident #022's plan of care, that was in place of the time of the fall in January 2017, indicated that the resident requires support for transfers as evidenced by inability to complete tasks on own, due to impaired cognition (Mild Dementia). The resident had several interventions in place related to transfers.

A review of the residents clinical health records indicated that a referral was sent to the Physiotherapist (PT) in January 2017, indicating the resident had fallen from a wheel chair and required an assessment. Further review of resident #022's clinical health records failed to identify documented evidence regarding the follow-up to the referral sent to the PT in January 2017, or that an assessment of the resident was completed by the Physiotherapist.

During an interview with the Physiotherapist in April 2017, by Inspector #607, the PT indicated that he/she did receive a referral in January 2017, for resident #022's fall, and further indicated that an assessment of the resident was not completed nor was a follow up to the referral documented.

During an interview with the Director of Care (DOC) in April 2017, by Inspector #607, the DOC indicated that PT referrals are completed after each falls, and the home's expectation is the PT will follow up and assess residents after each fall.

The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of resident #022 and #024 so that an assessments of the resident is integrated, consistent and complement each other, specifically related to the Physiotherapist not completing an assessment of the resident, after the resident slid from a wheel chair during a transfer by staff in January 2017, as well as related to when resident #024 fell, on an identified date April 2017, and was not diagnosed with an injury to a body part, related to the fall, until an identified day in April 2017, four days later. [s. 6. (4) (a)]

3. The licensee has failed to ensure that when resident #022 and #024 was reassessed, the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Re: Intake Log # 007632-17 related to resident #022:

A complaint was submitted to the Ministry of Health and Long Term Care on an identified date in April 2017, identifying multiple concerns including concerns related to provision of care related to falls and transfers by staff involving resident #022.

A review of the progress notes for resident #022, indicated the resident had a fall in January 2017, during a transfer involving two staff using a sit to stand lift. Further review of the progress notes documented in Point Click Care (PCC), indicated that during the transfer, involving resident #022, the staff attempted to transfer the resident from the floor to the bed, when they were unable to complete the transfer, they then attempted to transfer the resident back to the wheelchair when the resident slid from the wheelchair to the floor. In addition, the progress notes indicated that in April 2017, staff were transferring the resident from the bed to a wheelchair using a sit to stand lift, when the resident slid from the edge of the bed to the floor. The resident did not sustain any injuries from either falls.

A review of resident #022's plan of care, that was in place of the time of the fall in April 2017, indicated that the resident requires support for transfers as evidenced by inability to complete tasks on own due to impaired cognition (Mild Dementia), and several interventions in place related to transfers.

Record reviews indicated an assessment form for lifts and transfers was completed in November 2016, and there was no indication that after the resident fell using a sit to stand lift in January 2017, an assessment was completed for the suitability of the use of the sit to stand lift, until April 2017, after the resident had a second fall.

During an interview with Registered Practical Nurse (RPN) #102 in April 2017, by Inspector #607, the RPN indicated that Safe Ambulation Lift and Transfer (SALT) assessments are to be completed at least quarterly for residents, and further indicated a SALT assessment should have been completed for resident #022 prior to an identified date in April 2017.

During an interview with the Director of Care (DOC) in April 2017, by Inspector #607, she indicated that the home's expectation is SALT assessments be completed on a quarterly basis for all residents.

4. Resident #024 was admitted to the home on an identified date, with multiple diagnoses

including Dementia. A review of the plan of care in place at the time of the incident, indicated the resident was independent with ambulation.

A review of resident #024's progress notes indicated the resident had a fall in March 2017, sustaining injuries to a body part.

Interview with Registered Practical Nurse (RPN) #141 and Personal Support Worker (PSW) #140 in April 2017, by Inspector #607, both indicated that prior to the above identified fall incident, resident #024 would have wandered in and out of other residents rooms, but not off the unit.

During an interview with Environment Service Manager (EVS), by Inspector #607, he/she indicated that on the date of the above identified incident involving resident #024, he/she was walking along the corridors on the second floor in March 2017, when a family member indicated that a resident had fallen, at which time, he went to main floor and alerted the management staff of resident #024's fall.

A review of the video footage dated March 2017, by Inspector #607, the resident was observed to have exited through the unlocked doors of the home twice within a three minutes time period. Further review of the video footage, the resident was observed to have fallen two minutes after exiting the doors the second time around, to which the staff responded to the resident fall, six minutes later.

Further review of resident #024's progress notes dated April 2017, by Inspector #607, indicated the resident had fallen in another resident's room on the same date in April 2017, and was diagnosed with an injury to a body a part, four days later. A Critical Incident Report was submitted to the Director related to the incident.

During an interview with RPN #141 in April 2017, by Inspector #607, who assessed the resident at the time of the fall. The RPN indicated at the time of the incident, there was a page over the intercom for registered staff to report to the resident's fall immediately. The RPN further indicated upon arrival to the scene, she observed resident #024 sitting on the ground, bleeding from a body part. The RPN further indicated resident #024 was observed at the time of the fall to be wearing inappropriate footwear.

A review of the plan care in place after the resident #024 had fallen in March 2017, failed to identify interventions related to resident #024 new behaviours of wandering outside of the unit and the monitoring of the resident for safety.

Further interview with RPN #141, in April 2017, by Inspector #607, the RPN indicated he/she did not revise resident #024's care plan to include interventions related to the resident wandering, and further indicated there should have been interventions included in the residents plan of care related to the resident new behaviours of wandering off the unit and monitoring of the resident safety, after the incident of March 2017.

During an interview with the DOC in April 2017, by Inspector #607, the DOC indicated the home's the expectation is the staff should know where residents are at all time. The DOC further indicated that resident #024 is normally a wanderer, and indicated there should have been intervention in the resident plan care regarding monitoring of the resident related to wandering and safety.

The licensee failed to ensure that when resident #022 and #024 was reassessed, the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs change specifically related to the resident #024 wandering off the unit and monitoring of the resident's safety as well as related to lifts and transfers for resident #022. [s. 6. (10) (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 ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, specific to falls prevention and management, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Re: Intake Log #002044-16 involving resident #026 and #027:

Critical Incident Report (CIR) was submitted in January 2016, at an identified time to the Director. The CIR indicated an incident of physical abuse involving resident #026 and #027 resulting in injury to resident #027, which occurred on an identified date in January 2016, at an identified time.

The CIR describes that resident #027 was found by Personal Support Workers (PSW's) #142 and #143 laying on the floor in his/her room. Resident #026 was found standing at resident #027's feet. The incident was unwitnessed, resident #026 was removed from the room and given as needed (PRN) medications to decrease responsive behaviours. Resident #027 was assessed by Registered Practical Nurse (RPN) #144 for complaint of pain, and was later transferred to hospital for further assessment. RPN #144 indicated to Inspector #194, that there was no specific diagnosis from the hospital, but felt that the pain was a soft tissue injury.

Resident #027 is described by RPN #144 as ambulating with use of a mobility aid, being pleasant, but could display responsive behaviours when co residents came into his/her space.

Resident #026 is described by RPN #144 as having a history of responsive behaviours, if other residents interfered with him/her or when the environment was too noisy. RPN #144 further indicated that resident #026 was independent with ambulation without aids.

During an interview conducted by Inspector #194 in April 2017, RPN #144 who was charge nurse on the unit at the time of the incident, indicated that he/she had called the on call manager who was the Administrator, the night of the incident. Both the Administrator and RPN #144, indicated they could not remember if the Ministry of Heath and Long-Term Care (MOHLTC) had been immediately notified of the incident. There was no evidence that the Director was immediately notified by the licensee of the physical abuse between resident #026 and #027 in January 2016.

The licensee failed to ensure that the Director was immediately notified of an abuse or neglect of a resident by anyone by the licensee or staff that resulted in harm or risk of harm, or the information upon which it was based, specifically related to resident #026 and #027. [s. 24. (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 ensuring that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, is immediately report and the information upon which it was based to the Director, specifically related to resident #026 and #027., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) 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:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure the written report include a description of the individuals involved in the incident, including the names of any staff members or other persons who were present at or discovered the incident.

Re: Intake Log #006499-17 involving resident #023:

A Critical Incident Report was submitted to the Director in March 2017, for an incident for which a resident sustained injury and was transferred to hospital that occurred in March 2017.

The CIR identified Registered Practical Nurse's (RPN's) #127 and #128 as the ones who responded to the incident.

Interview with Personal Support Worker's (PSW's) #115 and #130, by Inspector #607, indicated they were either present or discovered the incident, but was not identified in the amended CIR.

The licensee has failed to ensure that the report to the Director included the names of the staff who were present or either discovered the incident, specifically related to resident #023. [s. 107. (4) 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 ensuring that the licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) 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: 2. A description of the individuals involved in the incident, including, i. names of any residents involved in the incident, ii. names of any staff members or other persons who were present at or discovered the incident, and iii. names of staff members who responded or are responding to the incident, specifically related to resident #023, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that its Abuse or neglect policy was complied with.

Re: Intake Log #002044-16 involving resident #026 and #027:

In January 2016, at an identified time, a Critical Incident Report (CIR) was submitted to the Director related to an incident of physical abuse that occurred on an identified date and time in January 2016, between resident #026 and resident #027 resulting in injury.

Review of the licensee's Investigation of abuse or neglect policy # ADMIN 1-010.02, dated July 2016, and "Resident non-abuse" Toolkit for conducting an alleged abuse investigation directs:

"Resident non-abuse" Toolkit for conducting an alleged abuse;

Step Four: Notifying the following:
-The Executive Director (ED), who should notify;
-Regulatory agencies as per jurisdictional regulations

Step Twelve: Report
- The ED or designee should:
-Report their findings to the appropriate agencies in accordance with jurisdictional regulations and within the required time lines.

During an interview with Registered Practical Nurse (RPN) #144, by Inspector #194 in April 2017, who was charge nurse on the unit at the time of the incident. The RPN indicated that he/she had called the on call manager who was the Administrator, the night of the incident, and indicated that the Director was not immediately notified of an incident of physical abuse that occurred in January 2016, at an identified time. Further interview with the Administrator indicated that the Director was not notified of the outcome of the investigation into the physical abuse.

The licensee failed to ensure that its investigation of abuse or neglect policy # ADMIN 1-010.02, was complied with, specifically related to reporting findings to appropriate jurisdictional regulations and within the required time lines, related to resident #026 and #027. [s. 20. (1)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of an abuse or neglect investigation was reported to the Director.

Re: Intake Log #002044-16 involving resident #026 and #027:

In January 2016, at an identified time, a Critical Incident Report (CIR) was submitted to the Director, regarding an incident of physical abuse that occurred on an identified time in January 2016, between resident #026 and resident #027 resulting in injury.

During an interview with the Administrator by Inspector #194 in April 2017, who was the on-call manager at the time of the incident, the Administrator indicated that the outcome of the abuse investigation involving resident #026 and #027 in January 2016, at an identified time, had not been reported to the Director.

The licensee failed to ensure that the results of the abuse or neglect investigation were reported to the Director, specifically related to resident #026 and #027. [s. 23. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident #017 was based on at a minimum, interdisciplinary assessment with respect to sleep patterns and preferences.

Resident #017 was admitted to the home on an identified date, with multiple diagnoses, that includes a neurological disease.

During an interview with resident #017 in April 2017, by Inspector #607, the resident indicated that staff would assist him/her to bed at a specified time and his/her preference is one hour later.

During an interview with Personal Support Worker (PSW) #107 in April 2017, by Inspector #607, the PSW indicated to Inspector #607, that resident #017 likes to stay up at nights to watch television, and further indicated the resident goes to bed at the resident's preferred specified time.

During an interview with Registered Practical Nurse (RPN) #108 in April 2017, by Inspector #607, the RPN indicated that resident #017 is able to vocalize when he/she is ready to go to bed, and further indicated that the resident often goes to bed at the resident's preferred specified time.

Review of the plan of care in place since admissions and current plan of care for resident #017, indicated the resident's sleep pattern and preferences were not included.

In April 2017, during interviews with the Director of Care (DOC) and RPN #108, by Inspector #607, both indicated that resident #017's sleep patterns and preferences were not included in the resident's plan of care. The DOC and RPN #108 further indicated the home's expectation is the resident's sleep pattern and preferences should be included in the plan of care.

The licensee failed to ensure the plan of care for resident #001 was based on an interdisciplinary assessment with respect to sleep patterns and preferences, specifically to not including interventions related to when the resident goes to bed. [s. 26. (3) 21.]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Record review indicated that one identified concern and one identified recommendation directed to the Environmental Services and the Recreation and Social Activities departments were raised during the February 2017, Residents’ Council meeting.

During an interview with a Resident Council team member in April 2017, by Inspector #607, indicated that a response was not provided to the above identified concern or recommendation to Resident Council.

During an interview with the Environment Services (EVS) Manager in April 2017, by Inspector #607, he/she indicated being aware of the concern brought forward by Resident Council during management meeting back in February, 2017. The EVS further indicated that he/she did not received a written concern form from Resident Council and therefore did not provide written response to the Council.

An interview with the Resident Council Assistant in April 2017, by Inspector #607, indicated being aware of the above identified concern and recommendation, and further indicated that written responses were not provide to the above identified concern and recommendation within the designated 10 day time.

Interview with the Administrator in April 2017, by Inspector #607, indicated that the expectation of the home is the Assistant to Resident Council would provide a written concern form from the Resident Council, and forward this form to him/her, so that a response can be provided within the designated time period.

The licensee failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns and recommendations specifically related to the Environmental Services and the Recreation and Social Activities departments. [s. 57. (2)]

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 17th day of May, 2017

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

Original report signed by the inspector.