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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 20, 2015	2015_371193_0007	T-1889-15	Follow up

Licensee/Titulaire de permis

FRIULI LONG TERM CARE
7065 Islington Avenue Woodbridge ON L4L 1V9

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

VILLA LEONARDO GAMBIN
40 Friuli Court Woodbridge ON L4L 9T3

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

MONICA NOURI (193), CECILIA FULTON (618)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): April 16, 17, 2015.

The inspectors observed the provision of care, reviewed residents' health records, applicable policies and procedures, staff education records.

During the course of the inspection, the inspector(s) spoke with residents, personal support workers (PSW), registered staff (RPN), physiotherapist (PT), Director of Care and the Administrator.

The following Inspection Protocols were used during this inspection:
Personal Support Services

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

- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 36.	CO #001	2014_168202_0024	193

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to resident #3.

Record review of the current care plan, kardex and the most recent PT assessment indicated the resident is to be transferred using a mechanical lift.
Observation of the resident's room revealed signage for sit/stand lift and mechanical lift at the head of bed.
Interview with primary care giver and other identified direct care staff indicated that they follow the signage at the head of bed when transferring the resident; mechanical lift in the morning when the resident is less alert, and sit/stand lift later on the day, when the resident is alert and follows directions, for toileting and showers.
Interview with an identified registered nurse confirmed that the signage and the care plan and kardex are not consistent and as a result do not provide clear direction to staff. [s. 6. (1) (c)]

2. 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 #3 so that their assessments are integrated, consistent with and complement each other.

Record review of the current care plan, kardex and the most recent PT assessment indicated the resident is to be transferred using a mechanical lift as resident #3 is non-weight bearing.
Observation of resident's room revealed signage for sit/stand lift and mechanical lift at the head of bed.
Interview with primary care giver and other identified direct care staff indicated that they follow the signage at the head of the bed when transferring the resident. The primary care giver stated that, on April 17, 2015, at approximately 7:30 a.m., the resident was transferred with assistance of another PSW from bed to the shower chair. The PSW stated that this is the usual practice for this resident if resident #3 is alert. The PSW uses daily the sit/stand to toilet the resident and on shower days as resident #3 is able to bear weight and hold on the lift.
Interview with the PT revealed that during the most recent quarterly assessment she assessed the resident as not following instructions and recommended the transfer mode to be with a mechanical lift. During this assessment the PT indicated that she did not consult with the resident's primary care giver or the registered staff.
The PT conducted an assessment on April 17, 2015, after the inspectors' review of the resident's health record. During this assessment the PT consulted with the resident's primary care giver and confirmed that the resident can be transferred using a sit/stand lift when the resident is alert. [s. 6. (4) (a)]

Issued on this 20th day of April, 2015

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

Original report signed by the inspector.