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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 20, 2017	2017_538144_0040	021098-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF ELGIN MUNICIPAL HOMES
39262 Fingal Line RR #1 ST. THOMAS ON N5P 3S5

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

BOBIER VILLA
1 BOBIER LANE DUTTON ON N0L 1J0

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

CAROLEE MILLINER (144), ADAM CANN (634), MARIAN MACDONALD (137)

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): September 12, 13, 14, 15, 2017

During the course of the inspection, the inspector(s) spoke with 20+ residents, three family members, one Residents' Council and one Family Council representative, the Administrator, Director of Care, two Registered Nurses, one Registered Practical Nurse, eight Personal Support Workers and two Recreation staff.

The following intakes were completed within the RQI:
Log 006343-16 Critical Incident M603-000001-16 related to required programs
Log 024794-16 Critical Incident M603-000010-16 related to administration of drugs
Log 024793-16 Critical Incident M603-000012-16 related to alleged staff to resident abuse
Log 003342-15 Critical Incident M603-000003-15 related to falls prevention and management
Log 020139-16 Critical Incident M603-000002-16 related to requirements to restraining and falls prevention and management
Log 016561-16 Complaint IL-44750-LO related to continence care and bowel management, prevention of abuse and neglect and the plan of care

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

2 WN(s)
1 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following right of one resident was fully respected and promoted:
One identified resident had the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

One resident sustained a fall resulting in hospitalization. A review of the progress notes for the date of the fall stated a Registered Practical Nurse (RPN) had notified the Substitute Decision Maker (SDM) and the doctor.

Further review of the progress notes showed a family member of the resident was visiting the home and was told the resident was in hospital. Continued review of the progress notes showed the family member said the family was not aware of this and called the Powers of Attorney (POA) who confirmed they were not contacted about the residents' hospitalization.

During a telephone interview the SDM for the resident said the home had not notified them about the hospitalization and they only became aware when a family member who was visiting at the home called them.

The Director of Care (DOC) said the SDM had not been notified of resident hospitalization. The DOC said an RPN documented that the SDM and doctor were notified but had not notified the SDM and failed to communicate to the day staff the need to contact the SDM to inform them of the resident's hospitalization.

The DOC said the home had failed to fully respect and promote the right of the resident to have their SDM informed immediately when the resident had fallen and was transferred and admitted to hospital.

The severity of this issue was determined to be a level two as there was minimal harm. The scope was isolated. There was no history of related non-compliance with this section of the legislation. [s. 3. (1) 16.]

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 each resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately, to be implemented voluntarily.

WN #2: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed no later than one business day of a medication incident or adverse drug reaction in respect of which a resident was taken to hospital.

Critical Incident System (CIS) report, M603-000010-16, was submitted to the Ministry of Health and Long-Term Care (MOHLTC) for an incident that occurred four days before the report was submitted. The incident resulted in a resident being taken to hospital.

During an interview, the Director of Care (DOC) said the Director of MOHLTC was not informed as required no later than one business day after an incident for which a resident was brought to hospital. [s. 107. (3)]

2. Critical Incident System (CIS) report, M603-000001-16, was submitted to the MOHLTC for an incident that occurred eleven days before the report was submitted. The incident resulted in a resident being taken to hospital. The MOHLTC after-hours pager was not contacted.

During an interview the DOC said the Director of MOHLTC was not informed as required no later than one business day of an incident that caused an injury to a resident for which the resident was taken to a hospital.

The severity of this issue was determined to be level two as there was minimal harm. The scope was isolated. There was no previous history of non-compliance with this section of the regulations. [s. 107. (3) 4.]

Issued on this 20th day of September, 2017

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

Original report signed by the inspector.