

**Inspection Report under
the Long-Term Care
Homes Act, 2007****Rapport d'inspection en vertu de
la Loi de 2007 sur les foyers de
soins de longue durée****Long-Term Care Operations Division
Long-Term Care Inspections Branch****Division des opérations relatives aux
soins de longue durée
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| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|--|---|---|--|
| Nov 3, 2021 | 2021_621755_0024 | 009800-21, 009938- 21, 015881-21, 016523-21 | Complaint |

Licensee/Titulaire de permisCentre d'Accueil Roger Seguin
435 Lemay Street Clarence Creek ON K0A 1N0**Long-Term Care Home/Foyer de soins de longue durée**Centre d'Accueil Roger Seguin
435 Lemay Street Clarence Creek ON K0A 1N0**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

MANON NIGHBOR (755), JULIENNE NGONLOGA (502)

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): October 6-8, 13-15, 18-22, 2021.

The following intakes were completed in this complaint inspection:

Logs #009938-21, #009800-21, #015881-21, #016523-21 were related to insufficient staffing, food services, nutrition, continence care, bathing, resident's injury and suspicion of resident abuse.

During the course of the inspection, the inspectors observed residents and staff interactions, provision of care and services, reviewed relevant clinical health records, policies, procedures and interviewed staff and residents.

During the course of the inspection, the inspector(s) spoke with the Administrator, Directors of Care (DOCs), Quality Improvement and Risk Management Coordinator, Resident Assessment Instrument Minimum Data Set Coordinator (Rai Coordinator), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Sitter, Food Services Manager, Registered Dietitian (RD), Dietary Aids (DAs), Environmental Services Supervisor, Maintenance Attendants, Screener and residents.

The following Inspection Protocols were used during this inspection:

Dining Observation

Hospitalization and Change in Condition

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Sufficient Staffing

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

2 WN(s)

2 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

| | |
|---|--|
| <p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p> | <p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p> |
| <p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p> | <p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p> |

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. (9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).

2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).

3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care of a 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.

The resident's plan of care directed staff to serve the resident first during breakfast meal service for medical reasons.

The resident was observed, sleeping in their room during breakfast. A staff member stated that they were directed not to wake the resident. Meals were offered to the resident when they got up later in the day. Staff indicated that the resident could sleep all day if no one woke them up. The RD stated that all restrictions were removed to accommodate their change in condition. DOC stated that some aspects of the resident's care remained in place to meet their needs. Dietary and nursing services did not collaborate in the development and implementation of the plan of care as it relates to the resident's nutritional needs and changing health status.

Sources:

Reviewed resident's relevant health care records including progress notes, plan of care and Food and fluid intake.

Interviews with RD and staff members.

2. The licensee has failed to ensure the personal care set out in the plan of care for three residents was documented.

The staff members were expected to document the care they provided to residents in the electronic flow sheet. There was no documentation found in the bath section of two resident's flow sheet. Two PSWs confirmed that the residents received a sponge bath that day and this was not documented. In addition, on a different day, one of the resident's morning care and incontinent care was not documented. Staff members confirmed that resident's morning care and incontinent care was provided and were not aware why it was not documented.

The resident's incontinent care was not documented for fourteen days. A staff member confirmed resident received incontinent care on on those days and did not know why it was not recorded. In addition, the resident's bath was not documented on a different day. Two staff members confirmed that the resident received their bath that day and could not recall why it was not documented. A staff member shared that staff were informed on the importance of documenting care to residents; that documentation had improved and was an ongoing concern. During the course of the interviews staff did not recall why the care provided was not documented. Staff stated that they bathed residents as a team of two PSWs and one of them documented the care delivered, they are assigned by care unit and not specific residents.

Sources:

MedECare, electronic flow sheet and plan of care of three residents.

Interviews with nine staff members.

3. The licensee has failed to ensure that the provision of care set out in the plan of care was documented for a resident.

The Point of Care (POC) documentation for food and fluid intake for 50 days showed blank spaces for 15 breakfasts, 7 lunches, 25 dinners, 7 morning snacks and 3 afternoon snacks.

Staff members stated that the resident was not always awake at mealtimes, but ate when they were up and sometimes had a second portions.

Reviewed resident's relevant health care records including progress notes, plan of care and Food and fluid intake.

Interviews with three staff members.

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 the provision of the care set out in the plan of care are documented is, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

- s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
- (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
 - (b) is complied with. O. Reg. 79/10, s. 8 (1).**

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any Policy and procedure, was complied with.

In accordance with O. Reg. r. 30. (1) 1 the licensee was required to ensure that Nutrition and Hydration program required under sections 8 to 16 of the Act and section 48 of the regulation, that there is a written description of the program that includes relevant policies, procedures and, protocols.

Specifically, staff did not comply with the licensee policy titled “Salubrité des aliments au service alimentaire. Gestion des risques”, SN-NUT 2505, revised in June 2017, which is part of the licensee’s Nutrition and Hydration program.

Under this policy, Dietary Aides were required to record cold and hot food temperature before each meal service.

Review of the food temperature recorded from October 1 to 17, 2021, lunch and dinner for both dining rooms on the first floor indicated that dietary aides did not record food temperature on 22 occasions prior to serving meals in both dining rooms. As such, there was a potential food safety risk.

Sources: Written food temperature records, home’s policy # SN-NUT 2505.
Interview with the Dietary Aide Food Services Manager and two staff members.

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 the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

Issued on this 4th day of November, 2021

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

Original report signed by the inspector.