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 # / No de registre	Type of Inspection / Genre d'inspection
Aug 9, 2018	2018_752627_0016	005813-18	Resident Quality Inspection

Licensee/Titulaire de permis

Geraldton District Hospital
500 Hogarth Avenue West GERALDTON ON P0T 1M0

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

Geraldton District Hospital
500 Hogarth Avenue West GERALDTON ON P0T 1M0

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

SYLVIE BYRNES (627), MELISSA HAMILTON (693)

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): July 30-31, August 1-2, 2018.

One Critical Incident system (CIS) report related to an injury, was also inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Long Term Care (LTC) Nurse Manager, Team Lead (T.L.) Coordinator, Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Recreational Aid (RA), residents and their family members.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed internal investigation notes, licensee policies, procedures, programs, relevant training and resident health care records.

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
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **1 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. 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

During a family interview, resident #004's family member stated that they were not sure if resident #004 was taking part in a specific activity of daily living (ADL), in a specific area of the home where the activity usually took place, and that they wished that the resident was assisted with the ADL at least once per day.

Inspector #627 observed resident #004 being assisted with the ADL in a specific area of the home which deferred from the usual area, where the ADL usually took place. The following day, the resident was observed being assisted with an ADL in the specific area of the home which deferred from the usual area, where the ADL usually took place. The resident was brought to another part of the home at a later time for the ADL, which was the usual area where the ADL took place.

Inspector #627 reviewed the care plan in effect at the time of the inspection and noted specific interventions indicating how and where the ADL should occur, at a certain time of day. At two different times, the ADL was to occur in the usual area of the home and that this intervention might be different under another focus due to a specific health condition. The other focus indicated that resident #004 was to continue to complete the ADL with assistance in two different areas of the home. For a third focus, it was indicated that the resident was to complete the ADL in one location of the home only.

Inspector #627 interviewed PSW #102 who stated that the resident was brought to a

specific area of the home, once a day only, to complete the ADL. They further stated that the resident had not been completing the ADL in the usual area of the home due to a medical condition in the past, therefore, the ADL was not always completed in the usual area of the home, at a specific time of the day.

Inspector #627 interviewed RPN #101 who stated that resident #004 was to compete the ADL at two different times during the day in the area of the home that the ADL usually occurred, and that the ADL occurred at another area of the home, once during the day. Upon review of the care plan with the Inspector, RPN #101 acknowledged that the care plan was confusing and had not provided clear directions to staff.

Inspector #627 interviewed the Long Term Care (LTC) Coordinator, who stated that the resident was to be brought to the usual area of the home to complete the ADL once a day only, to prevent a decline in the resident's health condition. The LTC Coordinator acknowledged that the care plan was confusing and had not provided clear directions to staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

During an interview with Inspector #627, resident #004's family member brought forth care concerns to Inspector #627. Please see WN #1, part one.

Inspector #627 reviewed the care plan in effect at the time of the inspection which indicated specific interventions for the focus of ADLs, in regards to resident's #004's medical conditions.

On a specific date, Inspector #627 observed that resident #004 did not have the specific intervention for their ADL in place. The following day, the resident was again without the specific ADL intervention in place.

Inspector #627 interviewed PSW #102 who stated that resident #004 did not have the specific ADL intervention in place. The PSW stated they followed what everyone was doing and didn't complete the intervention anymore. The PSW acknowledged that the resident's plan of care indicated the specific intervention, and that the care plan was to be followed by staff providing care.

Inspector #627 interviewed RPN #101 who stated that resident #004 should have had

have a specific activity in place when they took part in a certain ADL.

Inspector #627 interviewed the LTC Coordinator who acknowledged that resident #004's plan of care indicated that the resident was to be assisted with a specific ADL, and that care had not be provided as specified in the plan of care. [s. 6. (7)]

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 there is a written plan of care for each residents that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

Issued on this 10th day of August, 2018

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

Original report signed by the inspector.