**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 prévue 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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| May 1, 2019 | 2019_563670_0014 | 007420-19 | Complaint |

**Licensee/Titulaire de permis**

The Corporation of the County of Lambton
789 Broadway Street WYOMING ON N0N 1T0

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

North Lambton Lodge
39 Morris Street, R.R. #6 FOREST ON N0N 1J0

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

DEBRA CHURCHER (670)

## 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): April 24, 25 and 26, 2019.**

**The purpose of this inspection was to complete a Complaint Inspection.**

**The following complaint was inspected during this inspection;**
**Log#007420-19 IL-65697-LO related to alleged improper care related to falls and a decline in condition.**

**During the course of the inspection, the inspector(s) spoke with the Director of Care, the Acting Director of Care, two Registered Nurses, two Registered Practical Nurses, two Personal Support Workers and one Co-op Student.**

**The inspector also observed staff to resident interactions and the provision of care, completed relevant clinical record review and completed relevant review of the homes internal documentation.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Prevention of Abuse, Neglect and Retaliation**

**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<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #001 collaborated with each other, in the assessment of resident #001 so that their assessments were integrated and were consistent with and complement each other; and in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

The Ministry of Health and Long-Term Care received a complaint, IL-65697-LO related to concerns regarding alleged improper care.

Review of resident #001's clinical record showed that resident #001 was being treated for a medical condition and staff had noted changes in the resident's physical condition. The Physician was notified on a specific date and advised staff to monitor.

Progress note written by Registered Practical Nurse (RPN) #109, dated five days after the physician was notified, stated that resident #001 had a change in their mental status and also a change in their physical condition that required the use of additional medical equipment. Power of Attorney (POA) was notified.

Progress note written by RPN #109, dated seven days after the physician was notified, stated that resident #001 continued with mental status changes, had changed in their level of consciousness and required a higher level of physical assistance from staff for aspects of activities of daily living (ADL's) than they normally required. POA's had been in to visit and had asked to be kept updated.

Progress note written by RPN #110, dated seven days after the physician was notified,

stated that resident #001 had remained in bed all shift and was tired, had mental status changes, had a change in their level of consciousness and required a higher level of physical assistance for specific ADL's. POA's present for most of the shift.

Progress note written by RPN #110, dated seven days after the physician was notified, stated that resident #001 had a decreased level of consciousness and was restless and reaching arms out towards things. POA's were notified and expressed a concern regarding a specific condition that was not being treated. POA's were assured that the on call Physician would be notified.

Progress note written by RPN #110, dated seven days after the physician was notified, stated resident #001 continued to decline this shift, was unable to answer questions appropriately and had developed a specific symptom.

Progress note written by RPN #110, dated seven days after the physician was notified, stated writer placed call to both residents POA's and left message on both cell phones to call back for update on resident. No answer on either number. Writer wanting to clarify their wishes as far as sending resident to hospital if worsens or to keep here and monitor. Will update if phone call back received.

Progress note written by RPN #110, dated seven days after the physician was notified, stated writer spoke with physician who was on call and updated them on resident #001’s condition and what had been charted in the week leading up to resident's current condition. Physician ordered a specific intervention and a specific lab test for a specific date. Writer transcribed order into resident's chart and started interventions right away.

During an interview on April 25, 2019, with the Acting Director of Care (DOC) #101 they stated that without being present and assessing the resident during the time frame between when the physician was notified and the specific treatment was initiated, they could not say if the expectation would be that the physician would be notified of the change in condition in this instance, however it would be the expectation of the home that the physician would be notified of a significant change in condition.

During an interview on April 26, 2019, with RPN #109 they stated that they had worked the evening shift (3pm-11pm) five days after the physician was initially notified, with resident #001 and when they arrived for their day shift (7am-3pm) shift seven days after the physician was initially notified, they noted the resident wasn't doing well and had deteriorated mental status, deteriorated physical condition and required increased

physical assist with ADL's. RPN #109 stated that resident #001 had changed from their last shift worked two days prior. RPN #109 stated they had placed resident #001 outside of the nurses station in a recliner for closer monitoring and did notify the POA's. The POA's came in around at a specific time and RPN #109 stated that they spent approximately one to one and a half hours speaking with the daughters and the daughters felt maybe the resident had a specific condition and the POA's stated they wanted the physician called. RPN #109 stated a message was left for the on call physician approximately on half hour prior to the end of their shift but this was not charted due to being busy. RPN #109 stated they did not receive a call back from the Physician by the end of their shift so they informed the on-coming shift that they would need to try again. RPN #109 stated that they worked the day shift the following day after treatment had been initiated and did note an improvement in resident #001's condition. The resident was not 100% back to normal but improved. When the inspector asked why they had not notified the Physician until requested by the daughters seven days after the physician was initially notified of resident #001's change in condition, RPN #109 stated they were told that the resident was not doing well and had been declining.

During an interview on April 26, 2019, with Director of Care #108 who stated that they could not confirm if resident #001 had a change in condition as any variation could be a one off. DOC #108 stated that the physician should be notified of any change in condition.

The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #001 collaborated with each other, in the assessment of resident #001 so that their assessments were integrated and were consistent with and complement each other; and in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complement each other. [s. 6. (4)]

***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 staff and others involved in the different aspects of care of any resident collaborates with each other, in the assessment of any resident so that their assessments are integrated and are consistent with and complement each other; and 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, to be implemented voluntarily.***

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**Issued on this 2nd day of May, 2019**

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

**Original report signed by the inspector.**