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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 15, 2013	2013_214146_0022	H-000892-12, H-002255-12	Complaint

Licensee/Titulaire de permis

MARYBAN HOLDINGS LTD
3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6

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

OAKWOOD PARK LODGE
6747 OAKWOOD DRIVE, NIAGARA FALLS, ON, L2E-6S5

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

BARBARA NAYKALYK-HUNT (146)

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): March 27, 28, 2013.

This inspection included two complaints H-000892-12 and H-002255-12.

During the course of the inspection, the inspector(s) spoke with the Medical Director, Administrator, Director of Care (DOC), Associate DOC, registered staff, Personal Support Workers (PSW's), residents and family members.

During the course of the inspection, the inspector(s) reviewed discharged residents health records, current resident health records and policy and procedures.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 plan of care did not set out clear directions to staff and others who provided care to the resident.
a. The care plan for resident #002 stated a specific treatment to be done in the intervention column. The intervention did not give clear direction to the staff regarding details of the treatment such as where and when the treatment should be done.
b. The care plan intervention for resident #003 stated the resident had and preferred a tub bath. The resident and the record stated that the resident had and preferred a shower. This information was confirmed by the record, by a registered staff member and a PSW. The directions to staff were not clear
c. The care plan intervention for resident #002 under the problem of deafness stated "hears in special situations". This statement does not give any clear directions to caregivers.
d. The plan of care for resident #002 stated to "ensure that you speak in plain low tone into ". The intervention statement was incomplete and unclear and did not state where to speak into. This information was confirmed by the written care plan and staff.
e. An intervention on the care plan for resident #002 stated to do daily cleaning of teeth or dentures by staff or client. A second intervention stated to encourage resident to clean teeth every morning and every evening. These directions for dental care are confusing and unclear.
These findings were confirmed by the record, resident #003, the family of resident #002 and the DOC. [s. 6. (1) (c)]

2. The resident and the Substitute Decision Maker (SDM) were not given the opportunity to participate fully in the development and implementation of the plan of care.
a. In March 2012, resident #002, was transferred from the room the resident had occupied since admission to a different room without the consent or knowledge of the SDM. The family stated that they became aware of the move after the fact when they visited and couldn't find the resident. The resident was very confused and upset with the move because the orientation of the room was opposite to the former room i.e. Resident #002 had learned to turn to the left to go to resident #002's space in the old room but now occupied the right side of the room. The record confirms that the resident was more confused after the move. There is no rationale for the move, staff told family the move was made to have the resident closer to the dining room. The SDM was not given the opportunity to participate in the

plan of care.
b. Family of resident #002 attempted to participate in resident #002's plan of care by requesting to have an appointment with the resident's physician to discuss care concerns. The requests were documented in the record in March 2012 when the physician, who was present in the home, was notified of the request; and again in June 2012 when a nurse recorded that the family had been trying to speak with the resident's doctor for 3 months to no avail. When interviewed after discharge, the family stated that they never did get an appointment with a physician prior to the resident's transfer to another home. This information was confirmed by the record and the family member.
c.Resident #003 requested to have a specific food for breakfast several months ago. The resident stated that the request has been made on two occasions now because the requested food was not consistently supplied. The same resident asked for another change in the plan of care related to bed making. The resident requested assistance from staff in bedmaking. According to the resident, the assistance was denied by a staff person who stated the resident was to make the bed alone.
d. A dietitian's note on the record of resident #002 stated in January 2012 that the food service supervisor was notified that resident #002's family stated the resident ate much better when provided with a sandwich. The next entry in the record then states that the resident ate very poorly at supper time because no sandwich was provided as suggested by the family. [s. 6. (5)]

3. Care set out in the plan of care was not provided to the resident as specified in the plan.
a. Resident #002's plan of care included a December 2011 physician's order for a treatment. The treatment was mentioned in the interventions in the care plan. The treatment was applied inconsistently in December 2011 and was not mentioned again on the Treatment Administration Record (TAR) until March 2012 where there were no signatures to indicate the treatment was applied at all. This information was confirmed by the record and by registered staff.
b. Resident #002's plan of care included orders for specific medication to be given during the day and every night at bedtime. According to the Medication Administration Record (MAR), the bedtime medication was not given every night:
Aug 2012 - resident did not get the medication 16 out of 21 nights because sleeping (marked 7)
July 2012 - resident did not get 13 out of 31 days
Jun 2012 - did not get 15 out of 30 days due to sleeping

May 2012 - did not get 17 out of 31 days (7)
This information was confirmed by the record, the staff, the family and the DOC. [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 the plan of care sets out clear directions to staff and others who provide care, that the resident and the SDM are given the opportunity to participate fully in the development and implementation of the plan of care, and that care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. Any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were not documented.
a. Interventions related to medications and treatment programs were not documented, in that the dates were not supplied. A record review of resident #002 revealed that two treatment administration records (TARS) and three medication administration records (MARS) did not contain any date (month or year).
b. Interventions related to an ordered treatment was not documented. An undated TAR contained the treatment with boxes for a signature indicating application of the treatment and a box for a signature indicating removal. Only one day of the days signed for indicated both application and removal. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

Issued on this 15th day of April, 2013

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

BARBARA NAYKALYK-HUNT