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
Mar 10, 2014	2014_226192_0003	L-000045-14	Complaint

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

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

THE VILLAGE OF RIVERSIDE GLEN
60 WOODLAWN ROAD EAST, GUELPH, ON, N1H-8M8

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

DEBORA SAVILLE (192)

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): January 30, 2014 and February 18 and 20, 2014

This inspection was done concurrently with Critical Incident inspections #2014_226192_0005 (L-000071-14, L-000092-14) and #2014_226192_0006 (L-000041-14).
Long Term Care Homes Inspector Christine McCarthy participated in this inspection.

During the course of the inspection, the inspector(s) spoke with the General Manager, Assistant General Manager, Acting Director of Nursing Care, Assistant Director of Nursing Care, residents and family.

During the course of the inspection, the inspector(s) reviewed medical records, minutes of meetings and policy and procedure.

The following Inspection Protocols were used during this inspection:
Family Council
Infection Prevention and Control

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee failed to respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

Interview and record review confirm that Family Council held a meeting on August 29, 2013 where concerns were identified and shared with the home. A reminder was sent from Family Council to the Assistant General Manager on September 23, 2013 requesting response to the concerns and an email response was sent to Family Council on September 26, 2013.

Interview and record review confirm that Family Council held a meeting on September 26, 2013. An Issue's Report from Family Council to The Village of Riverside Glen was emailed and faxed to management of the home on September 30, 2013. Documentation provided and interview confirm that not all concerns identified by the Family Council during the September 26, 2013 meeting were responded to. The e-mail to Family Council from the General Manager dated October 15, 2013, indicated that concerns 12-19 had been responded to previously and no further response was provided. Responses to concerns 20 to 23 were provided. Request 19 included the provision of infection control protocols to the Family Council. As of January 30, 2014, Family Council had not received infection control protocols.

The licensee failed to respond in writing within 10 days of receiving Family Council concerns from the August and September 2013 Family Council meetings. [s. 60. (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 ensuring that Family Council receive a response in writing within 10 days of receiving advice related to concerns or recommendations, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff participate in the implementation of the infection prevention and control program.

Interview and policy review confirm that as part of the infection prevention and control program registered staff are to monitor residents for signs and symptoms of infection. When it is identified that a resident has developed two or more symptoms of respiratory infection they are to be added to the daily line listing.
When two or more residents present with two or more respiratory symptoms within a 48 hour time frame, the registered staff member is to initiate precautions clearly outlined in the home's Infection Control Policy and notify the Charge Nurse who will notify the Infection Control Nurse.

The home's line listing for January 2014 indicated that resident #002 presented with respiratory symptoms in 2014.

Record review and interview confirm that resident #001 presented with one respiratory symptom one day prior to resident #002, but had developed further symptoms within 48 hours and was diagnosed by the physician with a respiratory infection in 2014.

Resident #001 was not included in the home's January 2014 line listing in spite of presenting with two or more symptoms of respiratory infection. Interview confirms that no precautions were initiated and the presence of an outbreak as defined by the home's policy was not identified. [s. 229. (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 ensuring that the staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

Issued on this 10th day of March, 2014

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

D. Saville (192)