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
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
291 King Street, 4th Floor
LONDON, ON, N6B-1R8
Telephone: (519) 675-7680
Facsimile: (519) 675-7685

Bureau régional de services de London
291, rue King, 4iém étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 17, 2014	2014_202165_0005	L-000126-14	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

TAMMY SZYMANOWSKI (165)

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): February 19, 20, 2014

During the course of the inspection, the inspector(s) spoke with Puslinch Home Co-ordinator, Assistant General Manager, Assistant Director of Nursing, Director of Nursing, Registered Nursing Staff, Personal Support Workers, residents and families.

During the course of the inspection, the inspector(s) reviewed clinical health records of identified residents, the home's policies and procedures, the home's investigation notes related to clinical incident 2915-000010-14 and call bell records.

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

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 O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The staffing plan failed to provide for a staffing mix that was consistent with resident's assessed care and safety needs and that met the requirements set out in the Act and this Regulation.
A)Resident #002 reported that sometimes they had to wait an extended period of time for staff to respond to their call bell in the evenings when they required assistance to use the washroom. The resident reported that if the call bell was activated when staff take their breaks than it was ignored. The resident reported that sometimes they wait so long for staff that it becomes painful for the resident trying to control their bowels.
B) Resident #003 reported that in the evening call bells were always ringing. The resident reported that it was their preference to have their bath in the evening however, staff do not always come to bathe them. The home's bathing schedule indicated the resident was scheduled for a bath on an evening shift in February 2014, however, documentation and the resident confirmed that a bath was not provided. The resident reported that sometimes they get a bath in the evening and sometimes they do not.
C) Resident #004 reported that they have had to wait approximately forty minutes for staff to respond to their call bell on at least six occasions. The resident confirmed that while waiting for staff to respond they have become incontinent. It was reported that staff have been heard stating they were doing the best they could and residents were being demanding and ungrateful.
D) Resident's and staff interview indicated that call bells were not answered for extended periods of time during the evening shift. A review of call bell records during the month of February 2014, revealed that residents during the evening shift were waiting: one hour and 17 minutes, one hour and five minutes, 51 minutes, 49 minutes, one hour and thirty-eight minutes and one hour and six minutes for staff to respond.
E) The Neighborhood Co-ordinator reported that the home has historically had complaints related to resident's not receiving staff response for extended time periods in the evening. The Co-ordinator confirmed that the current evening staffing pattern did not meet the needs of residents.
F) Two critical incidents were reported in January 2014, during the evenings that confirmed in the neglect of two residents. [s. 31. (3) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee of the long term care home did not ensure that every resident's right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respects the resident's dignity was fully respected and promoted.
A) During an interview with resident #001, it was reported that the resident was not treated with dignity when they had expressed the need to be toileted. The resident reported that the PSW stated that they did not want to "waste" another clean brief. The PSW reported that it was already the resident's second change of the evening shift, they did not want to use another clean brief, and it was a lot of work to transfer the resident. The Assistant General Manager reported that staff were able to use as many briefs as the resident required and confirmed that the actions of the staff member were completed out of convenience not in promoting the the resident's right to be treated with dignity. [s. 3. (1) 1.]

2. The licensee of the long term care home did not ensure that every residents right not to be neglected by the licensee or staff was fully respected and promoted.
A) In January 2014, resident #001 approached the Registered Practical Nurse (RPN) and requested staff assistance to change their brief as they had been incontinent of a bowel movement. Interviews and staff statements confirmed that it was approximately two hours later that the resident received assistance to change their brief from the time staff were notified. The resident reported that they felt very angry when staff arrived to change the brief and that they had felt neglected by the inactions of staff. The Neighborhood Co-ordinator and the Assistant General Manager confirmed that the resident was neglected based on staffs inaction of the resident's request for assistance. [s. 3. (1) 3.]

3. The licensee of the long term care home did not ensure that the every resident has the right to be properly sheltered, fed clothed, groomed and cared for in a manner consistent with his or her needs were fully respected and promoted.
A) In January 2014, resident #001 received a dinner tray in their room. The resident reported that staff did not provide a table for the resident's dinner tray. The PSW placed the dinner tray at the foot of the resident's bed and rolled the bed up. The resident was in their wheelchair and had to reach onto the bed to feed themselves. The Neighborhood Co-ordinator confirmed that the home's expectation would be to place the resident's food on a table and indicated that placing resident's meal tray at the end of a bed for a resident to eat from was not acceptable practice in the home. [s. 3. (1) 4.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee did not ensure that all staff who provided direct care to residents received training related to the home's policy to promote zero tolerance of abuse and neglect of residents annually or based on the assessed training needs of the individual staff member.
A) An identified Personal Support Worker returned to work providing direct care to residents after a 15 month leave of absence in October 2013. The PSW and Assistant Director of Nursing confirmed that the staff member did not receive any training related to the home's policy to promote zero tolerance of abuse and neglect of residents since returning to the home four months ago. [s. 221. (2)]

Issued on this 28th day of March, 2014

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

Tammy Szymanowski

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	TAMMY SZYMANOWSKI (165)
Inspection No. / No de l'inspection :	2014_202165_0005
Log No. / Registre no:	L-000126-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 17, 2014
Licensee / Titulaire de permis :	OAKWOOD RETIREMENT COMMUNITIES INC. 325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	THE VILLAGE OF RIVERSIDE GLEN 60 WOODLAWN ROAD EAST, GUELPH, ON, N1H-8M8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	HEATHER CAUWENBERGHE

To OAKWOOD RETIREMENT COMMUNITIES INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
O. Reg. 79/10, s. 31 (3).

Order / Ordre :

The home shall prepare, submit and implement a plan to ensure that the staffing plan provides for a staffing mix that is consistent with residents assessed care and safety needs that meets the requirements set out in the Act and this Regulation specifically in the Puslinch Neighborhood.

The plan shall be submitted electronically to Tammy Szymanowski, Long Term Care Home Inspector for the Ministry of Health and Long Term Care, London Service Area Office, 130 Dufferin Avenue, 4th floor, London, Ontario, N6A 5R2 at tammy.szymanowski@ontario.ca

The Plan is to be submitted by March 31, 2014.

Grounds / Motifs :

1. The staffing plan failed to provide for a staffing mix that was consistent with resident's assessed care and safety needs and that met the requirements set out in the Act and this Regulation.
A)Resident #002 reported that sometimes they had to wait an extended period of time for staff to respond to their call bell in the evenings when they required assistance to use the washroom. The resident reported that if the call bell was activated when staff take their breaks than it was ignored. The resident reported that sometimes they wait so long for staff that it becomes painful for the resident trying to control their bowels.
B) Resident #003 reported that in the evening call bells were always ringing. The resident reported that it was their preference to have their bath in the evening however, staff do not always come to bathe them. The home's bathing schedule indicated the resident was scheduled for a bath on an evening shift in February 2014, however, documentation and the resident confirmed that a bath was not provided. The resident reported that sometimes they get a bath in the evening and sometimes they do not.
C) Resident #004 reported that they have had to wait approximately forty minutes for staff to respond to their call bell on at least six occasions. The resident confirmed that while waiting for staff to respond they have become incontinent. It was reported that staff have been heard stating they were doing the best they could and residents were being demanding and ungrateful.
D) Resident's and staff interview indicated that call bells were not answered for extended periods of time during the evening shift. A review of call bell records during the month of February 2014, revealed that residents during the evening shift were waiting: one hour and 17 minutes, one hour and five minutes, 51 minutes, 49 minutes, one hour and thirty-eight minutes and one hour and six minutes for staff to respond.
E) The Neighborhood Co-ordinator reported that the home has historically had complaints related to resident's not receiving staff response for extended time periods in the evening. The Co-ordinator confirmed that the current evening staffing pattern did not meet the needs of residents.
F) Two critical incidents were reported in January 2014, during the evenings that confirmed in the neglect of two residents. [s. 31. (3) (a)] (165)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 11, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 17th day of March, 2014

Signature of Inspector / Signature de l'inspecteur : Tammy Szymanowski

Name of Inspector / Nom de l'inspecteur : TAMMY SZYMANOWSKI

Service Area Office / Bureau régional de services : London Service Area Office