Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
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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 24, 2014	2014_226192_0011	L-000398-14	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): April 14, 15, 16, and 19, 2014

This inspection was conducted concurrently with complaint inspection L-000405 -14 and follow-up inspection L-000401-14

During the course of the inspection, the inspector(s) spoke with residents, family, the Acting Director of Resident Services, Assistant General Manager, Registered Nurses, Registered Practical Nurses, Resident Assessment Instrument Quality Improvement (RAI QI) Coordinators, Personal Support Workers, Behaviour Supports Ontario (BSO) Nurse, .

During the course of the inspection, the inspector(s) reviewed medical records, Behaviour Supports Ontario (BSO) assessments and documentation, and observed staff to resident interaction.

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.

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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. (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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. Previously issued October 16, 2013 as a Voluntary Plan of Corrective Action (VPC), July 15, 2013 as a VPC, October 19, 2012 as a VPC, June 17, 2011 as a WN.

The licensee failed to ensure that care is provided to the resident as specified in the plan of care.

A) Resident #001 required a treatment every two weeks to prevent re-occurrence of altered skin integrity.

Review of the medical record identified that signatures indicating that the resident had their treatment were not present in the a specified month in 2014, Medication Administration sheets for specified months in 2013 and 2014 were reviewed and identified that the treatment was not signed as being provided every two weeks.

Interview with the Acting Director of Resident Services and registered staff confirmed that if the treatment was not signed for it was likely not provided.

Observation of the resident identified that the treatment had not been provided and altered skin integrity was observed.

Interview with the resident, identified that their treatment had not been completed in the last two weeks and that the area was painful and itchy.

B) Review of the medical record for resident #001 indicated that the resident required

assistance with Activities of Daily Living (ADL's) and that the resident is to receive assistance with washing hard to reach areas "i.e. back and pericare."

Interview with the Resident Assessment Instrument Quality Improvement (RAI QI) Coordinator and the Acting Director of Resident Services confirmed the plan of care indicated that the resident would require intermittent to constant cuing to ensure personal hygiene is completed.

Interview with the resident who is able to recall care provided on specified dates in 2014 indicated that the resident did not receive assistance with washing of their back and the provision of perineal care, even though they had requested this assistance. Interview with the resident confirmed they had not received any assistance with care on the specified dates in 2014.

Resident #001 did not receive care as specified in their plan of care. [s. 6. (10) b]

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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents are fully respected and promoted: 11. Every resident has the right to, iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters.

A) The Substitute Decision Maker (SDM) for resident #001 identified that a change in long term care home was requested, but the SDM was discouraged by the management of the home from pursuing this change.

Interview with resident #001 in 2014 identified that they would like to move to another long term care home, but had not received any assistance in contacting the Community Care Access Centre.

Interview with the Assistant General Manager (AGM) and Acting Director of Resident Services in 2014 confirmed that a request had been made to have resident #001 moved to another home by the SDM. A family meeting was held. There was no finalization of the request to change long term care homes and the home has taken no further action to assist the resident and SDM, to date.

B) Resident #001 and their SDM identified that they had requested a change in physician both in writing and verbally.

Interview with the AGM and Acting Director of Resident Services confirmed a request for change in physician had been made. No action had been taken on this request.

C) During interview in 2014, resident #002 was identified by management of the home to have requested a change in long term care home.

Interview with resident #002 in 2014 confirmed that they had requested a move to another long term care home, but that this move was discouraged by management of the home and the physician. Resident #002 confirmed that they had not spoken to the Community Care Access Centre with regard to this request.

The licensee failed to respect the residents right to participate in decisions concerning any aspect of their care, including decisions concerning transfer to or from a long-term care home. [s. 3. (1) 11. iii.]

Issued on this 24th day of April, 2014

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

Debora Saville (192)

Ministry of Health and Long-Term Care

Ministére 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) :	DEBORA SAVILLE (192)
Inspection No. / No de l'inspection :	2014_226192_0011
Log No. / Registre no:	L-000398-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 24, 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:

Ministry of Health and Long-Term Care

Ministére 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

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that resident #001 is provided care based on assessed need and documented in the plan of care related to:

a. Specified treatment required every two weeks,
b. Assisting with caring for hard to reach areas such as the back and perineal area during the daily provision of assistance with personal hygiene.

Grounds / Motifs :

1. Previously issued October 16, 2013 as a Voluntary Plan of Corrective Action (VPC), July 15, 2013 as a VPC, October 19, 2012 as a VPC, June 17, 2011 as a WN.

The licensee failed to ensure that care is provided to the resident as specified in the plan of care.

A) Resident #001 required a treatment every two weeks to prevent re-occurrence of altered skin integrity.

Review of the medical record identified that signatures indicating that the resident had their treatment were not present in the a specified month in 2014, Medication Administration sheets for specified months in 2013 and 2014 were reviewed and identified that the treatment was not signed as being provided every two weeks.

Interview with the Acting Director of Resident Services and registered staff confirmed that if the treatment was not signed for it was likely not provided.

Observation of the resident identified that the treatment had not been provided and altered skin integrity was observed.

Interview with the resident, identified that their treatment had not been completed in the last two weeks and that the area was painful and itchy.

B) Review of the medical record for resident #001 indicated that the resident required assistance with Activities of Daily Living (ADL's) and that the resident is to receive assistance with washing hard to reach areas "i.e. back and pericare."

Interview with the Resident Assessment Instrument Quality Improvement (RAI QI) Coordinator and the Acting Director of Resident Services confirmed the plan of care indicated that the resident would require intermittent to constant cuing to ensure personal hygiene is completed.

Interview with the resident who is able to recall care provided on specified dates in 2014 indicated that the resident did not receive assistance with washing of their back and the provision of perineal care, even though they had requested this assistance. Interview with the resident confirmed they had not received any assistance with care on the specified dates in 2014.

Resident #001 did not receive care as specified in their plan of care.
(192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 02, 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.

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 24th day of April, 2014

Signature of Inspector / Signature de l'inspecteur : Debora Saville (192)

Name of Inspector / Nom de l'inspecteur : DEBORA SAVILLE

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