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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 21, 2015	2015_414110_0007	T-1763-15	Resident Quality Inspection

Licensee/Titulaire de permis

VICTORIA VILLAGE INC.
76 ROSS STREET BARRIE ON L4N 1G3

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

VICTORIA VILLAGE MANOR
78 ROSS STREET BARRIE ON L4N 1G3

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

DIANE BROWN (110), VALERIE JOHNSTON (202), VALERIE PIMENTEL (557)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): June 2, 3, 4, 5, 8 , 9, 10, 11, 12, 15, 16, 2015.

During the course of this RQI inspection a critical incident system(CIS) inspection T-1265-14 and a complaint inspection T-970-14 were completed.

During the course of the inspection, the inspector(s) spoke with director of care (DOC), assistant director of care (ADOC), registered staff, director of dietary and environmental services (DRFS), director of resident and family services, resident volunteer coordinator, rai-coordinator, physiotherapy assistant, personal support worker, dietary aide, resident companion and residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that different approaches have been considered in the revision of the plan of care when the resident is being reassessed and the plan of care is being revised.

Resident #10's plan of care for dental care required staff to provide extensive assistance with mouth care. The plan stated that the resident will often refuse hands on assistance from staff with oral care.

An interview with resident's companion stated that resident goes to the dental clinic every three months and that the clinic had advised that the resident's teeth needed to be better brushed in the home.

Record review revealed documentation by the oral hygienist on an identified date in 2015 and two previous dates three and six months prior in 2014 that the resident's oral hygiene "needs improvement".
Staff interviews revealed that the resident often refused to have staff brush his/her teeth.

Two quarterly assessment's in 2015, along with the plan of care did not identify different oral care approaches to improve resident's oral hygiene.
An interview with the ADOC confirmed that alternative approaches had not been considered. [s. 6. (11) (b)]

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 different approaches have been considered in the revision of the plan of care when the resident is being reassessed and the plan of care is being revised, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning techniques when assisting residents.

The plan of care for resident #01 directs staff to provide two staff assistance for all transfers which was further confirmed through staff interviews. Record review and staff interviews revealed that on an identified date, resident #01 fell in the tub room when the resident lifted him/herself from the commode. When the resident returned to the sitting position, the commode chair had moved and the resident missed the seat, landing on the floor in front of the toilet.
An interview with PSW #122, who was present in the tub room with the resident, revealed that he/she turned away momentarily, from view of the resident, to clean the resident's wheelchair, leaving the resident unsupervised when the resident fell. The PSW demonstrated to the inspectors the position of the commode over the toilet confirming that the commode was half over the toilet bowl leaving it incorrectly positioned. The PSW further confirmed that he/she had not locked the wheels on the commode prior to positioning the resident over the toilet, as he/she normally does. PSW #122 was unable to recall if another staff member assisted him/her with resident #01's transfer onto the commode chair, but stated that PSW #127 responded to his/her call bell to assist with resident #01, after observing that the resident had fallen.

An interview with PSW #127 who responded to the call bell, stated he/she could not recall if he/she assisted PSW #122 in the original transferring of resident #01 to the commode but did respond to the call bell assisting, PSW #122 with resident #01 after the resident's fall.

The home's policy Transferring a Resident Protocol dated November 2013 # VII-G-40.40(a) stated that "the PSW will lock all wheels on the equipment, unless otherwise indicated".

An interview with the ADOC confirmed that staff are expected to lock all wheels on a commode when the commode is positioned over the toilet and that it would be a safety concern if the wheels were not locked. [s. 36.]

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 staff use safe transferring and positioning techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that concerns raised by the Residents' Council are responded to in writing within 10 days.

A review of the Residents' Council meeting minutes indicated the following:

The minutes of March 27, 2014, revealed a concern that food discussions were taking too long at the Resident Council meetings and that concerns would be better discussed at another time. The written response to this concern was addressed at June 13, 2014, meeting.
The minutes of March 27, 2014, under section 3.0, entitled inspection program reports, revealed that the home had communicated to Residents' Council the licensee's requirement to respond to the Councils' concerns in writing within 10 days.

The minutes of October 14, 2014, identified two concerns;
1. A food committee meeting had not been held for a period of time,
2. Resident's clothing was being returned, wrinkled, from the laundry. The written response to these two concerns was addressed at the December 11, 2014 meeting.

The minutes of April 9, 2015, identified a concern regarding the cleaning of dining room tables after meals. The written response was addressed at the June 2, 2015 meeting.

Interviews with the resident volunteer coordinator, director of resident and family services and director of dietary and environmental services confirmed that the Residents' Council had not been responded to in writing within ten days of the concerns being raised. [s. 57. (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 concerns raised by the Resident's Council are responded to in writing within 10 days, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes review of meal and snack times by the Residents' Council.

A review of the Residents' Council meeting minutes from March 17, 2014, through to June 2, 2015, revealed the home has not reviewed the dining and snack times with the Residents' Council.

Interviews with resident #12 and #24 and management staff #123 and #129 confirmed the meal and snack service times were not reviewed by the Residents' Council. [s. 73. (1) 2.]

2. The licensee failed to ensure that residents are provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

On June 2, 2015, at lunch, in an identified dining room, the following was observed:
Resident #13 was observed being totally assisted with his/her soup until resident's soup was finished. The PSW then left to assist another resident. Resident #13 was then served his/her entrée at 12:55 p.m. with no staff assistance or encouragement until 1:02 p.m. The resident's plan of care stated that he/she required constant encouragement and that the resident feeds him/herself partially. Resident was not observed feeding him/herself between 12:55 p.m. and 1:02 p.m.
Resident #14 was served his/her soup at 12:37 p.m. while appearing to be asleep at his/her table. The resident remained asleep and was not provided supervision or awoken until 12:50 p.m. The resident's plan of care required the resident to be supervised at meals.

Staff interviews and observations revealed that one PSW moved around the dining room assisting five residents, while another PSW assisted four residents over the course of the lunch meal service. Staff were observed assisting or encouraging residents with one course then moving to assist another resident with their course, at a different table.

An interview with the DOC confirmed that residents #13 and #14 should have been provided encouragement and supervision and that staff should not be jumping around, assisting a number of residents over a course of the meal. [s. 73. (1) 10.]

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 home has a dining and snack service that includes review of meal and snack times by the Residents' Council and to ensure that residents are provided with personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with.

The home's policy Infection Prevention and Control, subject: Hand Hygiene, Policy # VIII-G-40-00, revision date of September 2013, identified that all staff will practice hand hygiene before and after administering medication by any route and before and after each resident contact.

On June 9, 2015, the inspector observed registered staff #128 complete a treatment and administer an injection for resident #26. During the two-step process, the registered staff completed the procedure at his/her bedside, returned to the medication cart, while assisting another resident in his/her wheelchair by pushing this resident to the dining room. The registered staff member signed off the electronic mar sheet then proceeded back to resident #26's room to administer an injection. During this process the registered staff member did not perform hand hygiene.
An interview with the DOC confirmed that the registered staff member did not follow the home's policy related to hand hygiene. [s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

On June 2 and 5, 2015, the inspector observed resident #07's wheelchair with an unclean, soiled adaptive seat cushion with a dried white substance on the resident's wheelchair hammock seat and frame.

Record review of the home's wheelchair cleaning schedule identified that resident #07's wheelchair had been cleaned during the night shift of June 4, 2015.

On June 5, 2015, the inspector confirmed with PSW #103, the resident's family member and the ADOC that the wheelchair was unclean and soiled. The ADOC confirmed that the home was aware that staff have not been following the wheelchair cleaning schedules for the past several months. Furthermore, the ADOC confirmed that although the cleaning schedule indicated that resident #07's wheelchair was cleaned the night of June 4, 2015, the chair did not appear clean the morning of June 5, 2015, when observed with the inspector. [s. 15. (2) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's menu cycle is reviewed by the Residents' Council for the home.

A review of the Residents' Council meeting minutes between March 17, 2014 and June 2, 2015, along with interviews with residents #12 and #24 and management staff #129 and #109 confirmed the home's menu cycle was not reviewed by Resident Council. [s. 71. (1) (f)]

Issued on this 3rd day of September, 2015

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

Original report signed by the inspector.