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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 2, 2019	2019_782736_0008	005245-19	Complaint

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

AMANDA BELANGER (736), TRACY MUCHMAKER (690)

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 23-26, 2019.

The following intake was inspected during the course of this Complaint inspection:
-One log related to a complaint regarding medication management, staffing, care concerns, and the management of complaints.

Critical Incident inspection #2019_782736_0009 and Follow Up inspection #2019_782736_0007 were conducted concurrently with this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing Services (DONS), the Associate Director of Nursing Services (ADONS), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and family members.

During the course of the inspection, the Inspector(s) also conducted a daily tour of the resident care areas, observed staff to resident interactions and the provisions of care, reviewed training records, complaint logs, and the home's policies and procedures.

The following Inspection Protocols were used during this inspection:
Medication
Minimizing of Restraining
Pain
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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	Légende 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified.

A complaint was submitted to the Director in regards to the care of resident #001. The complainant alleged that the home had not completed a specified treatment on the resident, medications were being administered incorrectly, medications administered were contraindicated for the resident, the resident was not being monitored appropriately and that the home had not responded to verbal and written complaints submitted.

In a telephone interview with Inspector #736, the complainant indicated that resident #001 had not had a specific treatment completed upon admission. The complainant further indicated that the resident had a change in health status on a specific date after admission, where one of the resident's vital signs was noted to be outside of the normal range related to the specific treatment.

Inspector #736 reviewed resident #001's health records and noted that on admission, a form indicated the resident was ordered to have a specific treatment completed, to monitor the resident's health status. The form also indicated that the resident was receiving a specific intervention, that was to be re-evaluated after the treatment was completed. The Inspector was not able to locate any results of the specific treatment on the resident's chart until months after the admission. The Inspector was unable to locate any monitoring results of the resident's health status. The Inspector also reviewed resident #001's health records and noted another form in the resident chart with the resident's name on it. The form was signed by the Medical Director of the home, however was not dated and did not have any interventions checked off.

In an interview with the Inspector, RPN #106 confirmed that resident #001 had specific additional monitoring ordered. RPN# 106 reviewed the resident's chart with the Inspector and was unable to locate any documents to indicate that the resident had been monitored.

In an interview with the Inspector, the DONS indicated that they had attempted to locate the records of the treatment that had been ordered, however the home had not been able to locate the results of the treatment. The DONS confirmed that the resident's specified treatment was part of the resident's plan of care, and as the home had not had the treatment completed, care had not been provided as per the plan of care. [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 is provided to the resident as set out, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that included the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the

action, the final resolution, every date on which any response was provided to the complainant and any response made by the complainant.

A review of the policy, titled "Complaints- Response Guidelines", I-F-42.00, last revised October 2018, indicated that for written and verbal complaints, the home was to ensure that documentation included the nature of the verbal or written complaint, the date the complaint was received, the type of actions taken to resolve the complaint, including date of action, time frames for action and any follow up action required, the final resolutions, every date on which any response was provided to the complainant and description of the response, and, any response made by the complainant.

A) A complaint was submitted to the Director regarding the care provided to resident #001. Please see WN #1 for further details.

Inspector #736 spoke with the complainant who indicated that there had been complaints submitted verbally and in writing to the home's DONS and Associate Director of Nursing Services (ADONS) related to the care provided to resident #001.

The Inspector requested the home's records of complaints from the DONS and received the home's Complaints Binder. The DONS confirmed to the Inspector that all the home's records of complaints and follows up records would be in the Complaints Binder. The Inspector reviewed the Complaints Binder of the home and was unable to locate the complaint or follow up record from the home indicating: the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, the final resolution, every date on which any response was provided to the complainant and any response made by the complainant, in relation to the complaint of resident #001.

The Inspector spoke with the DONS, who indicated that they were aware of the care concerns that were made by a person known to resident #001, however the home did not formally respond or keep record of the complaint, as the person known to resident #001 was not considered the Substitute Decision Maker (SDM). The DONS further indicated that the home's "Verbal Complaint/Concern Form" should have been filled out to document the complaint and the home's response, and it was not.

The Inspector spoke with the Administrator who indicated that the process in the home would be that anyone who receives a verbal or written complaint would utilize the home's internal "Verbal Complaint/Concern form" and all complaint forms would be put into the

home's complaint binder. The Administrator could not locate any follow up from the home, or documentation related to the complaint from the person known to resident #001's in the complaint binder. The Administrator further explained that staff members may have followed up verbally with the complainant, as the complainant had ongoing care concerns, however the home had no record of the follow up that had occurred.

B) A complaint was submitted to the Director regarding the care provided to resident #005.

Inspector #736 reviewed the home's Complaint Binder and could not locate any complaint form related to the resident or complainant concern or the follow up record from the home indicating: the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, the final resolution, every date on which any response was provided to the complainant and any response made by the complainant.

In an interview with the Inspector, the DONS indicated that for resident #005, the home had not filled out the "Verbal Complaint/Concern" form, but was unsure why it had not been filled out. The DONS further indicated that the form should have been filled out in relation to the concerns brought forward by resident #005 and the complainant.

The Inspector spoke with the Administrator, who indicated that they were aware of the concerns expressed by resident #005 and the complainant. They further indicated that there was no written record of the complaint or the follow up from the home, as they felt it was dealt with right away by the Restorative Care Coordinator.

C) The Inspector reviewed an email complaint from a complainant, who had indicated to the DONS that they were upset with the care provided to a resident.

The Inspector reviewed the home's Complaint Binder and could not locate the complaint or follow up record from the home indicating: the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, the final resolution, every date on which any response was provided to the complainant and any response made by the complainant.

In an interview with the Inspector, the DONS indicated that they were aware of the complaint, however, it was addressed the next day at a meeting. The DONS indicated that a "Verbal Complaint/Concern form" should have been filled out, but could not recall

why it was not completed.

The Administrator indicated to the Inspector that they were unaware of the complaint email that had been submitted to the home's DONS. The Administrator read the email that had been provided to the Inspector, and indicated that it could have been viewed as a complaint and had care issues that "needed to be dealt with". The Administrator could not locate any written record from the home related to the complaint or the follow up actions by the home, however, indicated that there should have been a record. [s. 101. (2)]

2. The licensee has failed to ensure that the documented record of complaints received were reviewed and analyzed for trends at least quarterly, and a written record was kept of each review and of the improvements made in response.

A review of the policy titled, "Complaints-Response Guidelines", I-F-42.00, last reviewed October 2018, indicated that the home would, on a quarterly basis discuss all complaints that required a written response at the Executive Leadership and Quality Committee, document the records reviewed and analyzed for trends, the results of the analysis and would retain a copy of a written record of each review and the improvements made.

In an interview with the Administrator they indicated to the Inspector that the home analyzed complaints on an annual basis, with the last time, being June of last year. The Inspector asked the Administrator to provide the last quarter analysis of complaints and the written record that was kept of the review and the improvements made in response to the analysis. The Administrator provided a copy of the "Victoria Village Manor Management Meeting" minutes from March 25, 2019, which under the complaint section, indicated that there were several complaints, most from nursing and dietary and that the home "was receiving lots of them" [complaint forms]. The Administrator confirmed that there was no analysis available of the last quarter of complaints, other than at the management meeting, and that the plan was to move forward to an annual process where the complaint binder would be analyzed. [s. 101. (3)]

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 keeps a written document that includes the nature of each verbal or written complaint received, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, the final resolution, every date on which any response was provided to the complainant and any response made by the complainant, and that these documents are reviewed on a quarterly basis, and a record is kept of each quarterly review including trends and improvements made in response, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee immediately forwarded any written complaints that had been received concerning the care of a resident or the operation of the home to the Director.

A complaint was received by the Director regarding the care of resident #001. See WN #1 for further details.

Inspector #736 spoke with the complainant who indicated that there had been written complaints sent to the home's DONS and the ADON through email.

The Inspector reviewed two email complaints from a person known to resident #001, received by the DONS and ADONS on two separate dates. The written complaints indicated that there was concern about the care provided to resident #001.

On December 18, 2018, the Director notified the Long-term Care Homes, via the Ministry of Health and Long Term Care Homes Portal of "Important reference materials on the mandatory reporting requirements", specifically a question and answer document titled "Reporting QA MOH". The Reporting QA MOH indicated that written email complaints to the home were considered written complaints and were to be reported as per legislative requirements.

A review of the policy, titled "Complaint's-Response Guidelines" I-F-42.00, last revised October 2018, indicated that for written complaints, at the end of the investigation, the home was to provide a written response to the to notify the MOHLTC Inspector through the Centralized Intake, Assessment and Triage Team (CIATT).

In an interview with the Inspector, the DONS indicated that their understanding of the home's policy was that written complaints were only forwarded to the Director after 10 days if they were not able to be resolved. The DONS also indicated that the home's policy did not indicate whether or not an email was considered a written complaint. The DONS further indicated that the home did not consider the email a written complaint as the complainant was not the SDM of a resident. The DONS confirmed that the written complaint had not been forwarded to the Director, as they were unaware that it was a requirement.

In an interview with the Administrator, they indicated that they were aware of the requirement to forward written complaints that the licensee received to the Director, immediately. The Administrator further indicated that they were unaware if the complaint in relation to resident #001 had been forwarded to the Director, as it was received through email, and they were unsure if emails were considered written complaints. [s. 22. (1)]

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Ministère de la Santé et des Soins de longue durée

Rapport d’inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Issued on this 3rd day of May, 2019

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

Original report signed by the inspector.