Ontario

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 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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 3, 2019	2019_670571_0023	021203-19	Complaint

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

The Village of Taunton Mills
3800 Brock Street North WHITBY ON L1R 3A5

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

PATRICIA MATA (571)

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): November 14, 15 and 18, 2019.

The following intakes were inspected during this complaint inspection:

Log #021203-19 related to a complaint regarding falls management, medication, plan of care and personal care.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Assistant Director of Care (ADOC), Neighbourhood Co-ordinator (NC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Assistants (PCA) and the resident.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 Substitute Decision Maker (SDM) was informed of resident #008's change to a medication order.

Related to Log #021203-19:

An anonymous complaint was submitted to the Director on a specified date. The complaint included a concern that the substitute decision maker (SDM) of resident #008 was not notified of medication changes.

On a specified date, the Physician of resident #008 changed the dosage of an identified medication. The order was processed by Registered Nurse (RN) #101 and second checked by Registered Practical Nurse (RPN) #100 on the same date.

In an interview with Inspector #571, RPN #100 could not remember if they informed the SDM of the change to the medication order. The RPN did not document that the SDM had been informed.

In an interview with Inspector #571, RN #101 indicated that they did not document that they had informed the SDM about the change to the medication.

After review of resident #008's clinical health record, evidence that the SDM was informed of the change to the medication order could not be found.

The SDM had not been provided the opportunity to participate fully in the development and implementation of the plan of care. [s. 6. (5)]

2. The licensee failed to ensure when an assistive device was ordered for use by resident #008 that it was implemented as per the plan of care.

Related to Log #021203-19:

An anonymous complaint was submitted to the Director on a specified date regarding a failure of the licensee to follow the plan of care.

A review of the clinical record indicated that on a specified date, Kinesiologist #107 documented that they had assessed resident #008 after receiving a referral related to a specified incident. The Kinesiologist indicated that a specified assistive device would be added to the resident's plan of care. Thirty-two days after the assessment, the assistive device was implemented for the resident after a second incident.

Kinesiologist #107 was not available for an interview.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified. [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 resident's substitute decision-maker and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 3rd day of December, 2019

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

Original report signed by the inspector.