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

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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
Nov 20, 2019	2019_803748_0010	014796-19, 020447-19	Complaint

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

West Oak Village
2370 Third Line OAKVILLE ON L6M 4E2

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

EMMY HARTMANN (748)

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): October 28, 29, 30, 2019.

The following intakes were completed in this Complaint Inspection:

Log #020447-19, was related to concerns about resident care.
Log #014796-19, was related to concerns about medication and plan of care.

During the course of the inspection, the inspector(s) spoke with residents, Executive Director, Acting Director of Care, Regional Manager of Clinical Services, Medical Director, Registered Dietitian (RD), registered nurses (RN), registered practical nurses (RPN), and personal support workers (PSW).

During the course of the inspection, the inspector also observed the provision of care and services, and reviewed records, and policies.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. The licensee failed to ensure that there was a written plan of care for each resident that sets out,
(a) the planned care for the resident;

A: Log #014796-19, was a complaint submitted to the MOLTC, related to concerns about resident #003's medication not being administered and their plan of care not being followed.

A review of resident #003's records, identified that the resident had responsive behaviours, and that a part of the interventions to their behaviours, was to keep their routine consistent.

Observation of resident #003's room, identified signs directing staff to the resident's routine.

A review of resident #003's records, identified that it did not include the resident's sleep patterns and preferences.

Interview with PSW #109, identified that staff used the Kardex from Point of Care (POC) tasks, to find the care to be rendered to residents. They indicated that the resident's patterns and preferences, would be included in the care plan.

Interview with RPN #108, confirmed that staff followed the signs in resident #003's room, and that the resident's routine related to their sleep patterns and preferences were missing from the care plan.

B: Log #020447-19, was a complaint submitted to the MOLTC, related to concerns regarding the care of resident #001.

A review of the resident's care plan identified that it did not include the resident's sleep patterns and preferences.

Interview with RPN #111, confirmed that resident #001's sleep patterns and preferences were missing from the care plan.

C: Log #020447-19, was a complaint submitted to the MOLTC, related to concerns regarding the care of resident #002.

A review of the resident's care plan identified that it did not include the resident's sleep patterns and preferences.

Interview with RPN #111, confirmed that resident #002's sleep patterns and preferences were missing from the care plan.

Interview with Acting DOC identified that it was their expectation that the care plan included the planned care for the residents, and they acknowledged that resident #001, resident #002, and resident #003, should have had their sleep patterns and preferences in their care plan. [s. 6. (1) (a)]

2. The home failed to ensure that the care set out in the plan of care was provided to resident #001, as specified in the plan.

Log #020447-19, was a complaint submitted to the MOLTC, related to concerns regarding the care of resident #001.

A review of resident #001's progress notes, documented on an identified date and time, indicated that the resident had a change in condition, and the doctor was called. The resident was subsequently transferred to hospital for assessment.

A review of resident #001's care plan identified that they had a medical condition that was being monitored. The care plan indicated that if the resident's lab value related to ther medical condition was to be above a certain level, that staff were to complete the intervention of a referral to the registered dietitian (RD).

A review of the resident's lab results for two identified service dates, revealed that the resident's lab value was over the certain level, identified in the resident's care plan.

A review of referrals to the dietitian identified that the referrals were not completed on the two identified dates.

Interview with the RD confirmed that they did not receive referrals related to the resident's lab values, as per the resident's care plan.

Interview with the Acting Director of Care identified that it was an expectation that staff follow the plan of care as set out in the care plan, and that a referral to the dietitian was made as outlined in resident #001's plan of care. [s. 6. (7)]

3. The licensee failed to ensure that resident #001 was reassessed and their plan of care was reviewed and revised when their care needs changed or when the care set out in the plan was no longer necessary.

Log #020447-19, was related to a complaint regarding concerns of improper care of resident #001, which included oral hygiene.

A review of resident #001's care plan identified that the resident required support for their oral hygiene related to their cognitive impairment, disease process, and decrease in strength. Specifically, the care plan included the interventions of supervision and set up assistance in the area of mouth care.

Interview with PSW #110, identified that they were familiar with the care of resident #001, and that the resident required more than set up assistance and supervision, as the resident was no longer able to complete this on their own.

Interview with PSW #113, identified that they were familiar with the care of resident #001, and they did not report the change to the nurse to update the resident's plan of care.

Interview with the Acting Director of Care identified that it was their expectation that the care plan was reviewed and revised, and they acknowledged that the resident's assistance level for oral care should have been updated when the resident required more assistance. [s. 6. (10) (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 there is a written plan of care for each resident that sets out the planned care for the resident, to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, and to ensure that residents are reassessed and their plan of care is reviewed and revised when their care needs change or when the care set out in the plan is no longer necessary, to be implemented voluntarily.

Issued on this 2nd day of December, 2019

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

Original report signed by the inspector.