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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 26, 2014	2014_348143_0007	O-000510-14	Resident Quality Inspection

Licensee/Titulaire de permis

AON INC.
33 HARBOUR SQUARE, SUITE 825, TORONTO, ON, M5J-2G2

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

MOIRA PLACE LONG-TERM CARE HOME
415 RIVER STREET WEST, TWEED, ON, K0K-3J0

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

PAUL MILLER (143), AMBER MOASE (541), BARBARA ROBINSON (572)

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 10th-13th and 16th-19th, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, the Director of Resident and Family Services, the Life Enrichment Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, a Registered Dietitian, the Dietary Department Supervisor, family members, residents and the President of the Resident Council.

During the course of the inspection, the inspector(s) completed tours of all resident home areas, observed dining service, medication administration, medication drug storage area, infection control practices, observed resident care and services, reviewed resident health care records, policies and procedures as well as staffing schedules.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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 O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s. 26(3)21 in that the plan of care is not based on an interdisciplinary assessment of the resident's sleep patterns and preferences for the resident.

During an interview with Inspector #541, Resident #917 stated she\he was made to go to bed early one night and further stated she\he does not like to go to bed early. On June 16th, 2014 the care plan for Resident #917 was reviewed and there is no identification of sleep patterns or preferences for this resident.

The care plan for Residents #881 and #892 were reviewed and their sleep patterns and preferences are not identified.

On June 17, 2014 during an interview with Inspector #143 the Director of Care (DOC) confirmed that the resident's sleep routines and preferences are not included in the resident's plan of care. [s. 26. (3) 21.]

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 all resident's plan of care identify sleep patterns and preferences, to be implemented voluntarily.

WN #2: 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).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6 (1)(a), whereby the licensee did not ensure that the written plan of care for the resident sets out the planned care for the resident.

The Skin/Treatment note on a specified date states that Resident #917 has open areas on her\his coccyx. The resident's most recent care plan states that Resident #917 has a reddened area that requires treatment every 3-7 days.
The "Head to Toe" quarterly assessments from March 14, 2014 and June 4, 2014 do not list any ulcers.
On a specified date staff #127 confirmed that the written plan of care for resident #917 does not set out the planned care in terms of the resident's skin and wound care.

When interviewed on a specified date Staff #116 RPN noted that Resident #950 has respiratory problems and confirmed with the inspector that the plan of care did not address Resident #950's respiratory care needs.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The Licensee has failed to comply with the Long-Term Care Homes Act section 8(3) by not ensuring that a Registered Nurse is present and in the home at all times.

Moira Place is 128 bed Long Term Care Home.
On June 10th, 2014 Inspector #143 requested a copy of the Registered Nurses (RN) schedule. The Director of Care (DOC) provided the inspector with the schedule for the period June 2nd-15th, 2014. A review of the schedule indicated that on June 6th and 7th that no RN was present on site in the home from 1900 hours to 0700 hours. The DOC reported that no RN was available and that an additional Registered Practical Nurse was called in. The DOC reported that she was on call and available to staff if necessary. A review of the RN schedule for the two week period prior to and following the June 2-15th, 2014 schedule indicated that a RN was scheduled and present for the assigned shifts to date.
Ontario Regulation 79/10 section 45.(2) indicates that "emergency" means an unforeseen situation of a serious nature that prevents a Registered Nurse from getting to the long-term care home.
The two shifts were not identified as a case of an emergency where the exception as per Ontario Regulation 45.(1)1.ii would apply. [s. 8. (3)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 107 (3.1) whereby the licensee did not ensure that an injury to a resident that resulted in a significant change in the resident's health condition was reported to the Director within three business days.
The progress notes state that on a specified date and time Resident #844 fell and was hospitalized.
In an interview with the DOC stated that she initially waited to determine the extent of the resident's injuries and she did not submit the Critical Incident Report 2977-000010 -13 until seven days following the fall. The Director was not notified of the resident's injury within three business days. [s. 107. (3.1)]

Issued on this 26th day of June, 2014

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