Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Mar 1, 2021	2021_643111_0003	025431-20, 025439-20	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

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

Thorntonview
186 Thornton Road South Oshawa ON L1J 5Y2

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

LYNDA BROWN (111)

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): February 1 to 4, 2021

Two complaints were inspected concurrently during this inspection:
-complaint related to personal support services, nutrition and hydration, laundry and pain.
-complaint related to Infection, Prevention and Control (IPAC) and staffing.

Additional non-compliance was identified related to IPAC and was identified under Inspection #2021_643111_0002.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSW) and the resident.

During the course of the inspection, the Inspector reviewed health care records, observed the resident and the residents room, and bath lists.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Infection Prevention and Control
Nutrition and Hydration
Pain
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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 :

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

A complaint was received by the MLTC regarding the resident being improperly dressed. The plan of care indicated the resident was able to dress them self, required intermittent supervision, the registered staff were to check daily that the resident was appropriately dressed and document. Review of a two month period indicated there was only a number of dates when the staff documented that the resident was dressed appropriately and during that time, an RN confirmed the resident would have required increased supervision, due to illness.

Sources: complaint, care plan, progress notes and physician orders for a resident. Interview and observation of the resident and interview with an RN.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

The licensee has failed to ensure that a resident was bathed, at a minimum, twice a week, as per their choice.

A complaint was received by the MLTC regarding bathing not provided. The resident's preference was for two baths per week and review of the bathing provided to the resident indicated the resident had not received their twice weekly baths during a specified two month period. An RN confirmed if the staff were unable to provide their bath, they were to report this to the registered staff and they had no awareness that the resident had not received their baths. The lack of bathing to a resident as per their preference could impact the residents health and well-being.

Sources: care plan, bath list, progress notes and Point of Care (POC) for a resident. Interview with the resident and staff.

Issued on this 8th day of March, 2021

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

Original report signed by the inspector.