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
Jun 17, 2019	2019_730593_0016	008179-18, 011377-18, 028352-18, 007082-19	Complaint

Licensee/Titulaire de permis

The Corporation of the City of Kawartha Lakes
26 Francis Streeet P.O. Box 9000 LINDSAY ON K9V 5R8

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

Victoria Manor Home for the Aged
220 Angeline Street South LINDSAY ON K9V 4R2

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

GILLIAN CHAMBERLIN (593), ANANDRAJ NATARAJAN (573)

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): May 27 - 31, 2019.

The following complaint intakes were inspected:

Log #008179-18 related to staffing of registered nurses.
Log #011377-18 related to concerns regarding assistance with meals.
Log #028352-18 related to misuse of MOHLTC funding.
Log #007082-19 related to allegations of neglect toward a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nursing Staff, Dietary Staff, Personal Support Workers (PSW) and residents.

The Inspector(s) observed the provision of care and services to residents, staff to resident interactions, resident to resident interactions, residents' environment, reviewed resident health care records, staffing schedules and licensee policies and procedures.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Pain
Personal Support Services
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **2 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. 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 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 was on duty and present in the home at all times, except as provided for in the regulations.

In this section "regular nursing staff" means a member of the registered nursing staff who works in a long-term care home at fixed or prearranged intervals.

Victoria Manor Home for the Aged has a licensed bed capacity of 166 beds.

Inspector #573 reviewed the registered nursing schedule report for April 2018, in the presence of the Director of Care (DOC). It was determined that on April 19, 2018 (2300 hours to 0700 hours) night shift did not have a regular Registered Nurse (RN) on duty and present in the home.

During a review of the registered nursing schedule report from March 01, 2019 to May 28, 2019 it was determined that on April 20, 2019 (1500 hours to 2300 hours) evening shifts, and on May 02, 2019 (2300 hours to 0700 hours) night shift, did not have a RN on duty and present in the home.

The DOC confirmed that there was no RN on duty and present in the home on April 20, 2019 (1500 hours to 2300 hours) evening shift and on May 02, 2019, (2300 hours to 0500 hours) night shift. In discussion with the DOC, they indicated that the regularly scheduled registered nurses had unexpected leaves of absence on the above identified dates, which impacted upon the home's ability to provide at least one registered nurse on duty and present at all times. (log #008179-18) [s. 8. (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 ensuring 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, 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. (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 for resident #007 was provided to the resident as specified in the plan.

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC), regarding dietary and feeding assistance concerns for residents residing in a specific home area.

A review of resident #004's documented plan of care and dietary kardex found specific dietary requirements for meals and snacks. It also documented that entree is not to be removed until meal service has been completed even if resident #004 is refusing meal.

Inspector #593 observed several meal and snack services provided to residents in a specific home area.

During the breakfast meal service May 30, 2019, Inspector #593 observed resident #004 in the dining room. The resident was not provided with fluids, specifically documented in their plan of care. A meal was provided to resident #004 at 0913 hours, assistance was provided on and off during the meal service by PSW #121 until they left the dining room at 0930 hours. PSW #121 communicated to PSW #122 that resident #004 required further assistance. At 0937 hours, PSW #122 assisted resident #004 out of the dining room. No further food was offered to the resident, approximately 50% of the meal remained.

During the nourishment/snack service May 30, 2019, Inspector #593 observed PSW #121 provide a specific beverage to resident #004. Foods and fluids were not provided to the resident as documented in the plan of care.

During an interview with Inspector #593 May 30, 2019, PSW #121 indicated that they were the primary PSW for resident #004 on day shift and that there were no special food or fluid requests/requirements for resident #004. PSW #121 further said that resident #004 needed extra time to finish their meal and that they were one of the residents

served first as they needed to the meal in front of them for up to an hour, to be finished. PSW #121 said that for the 1030 hours nourishment pass, the resident should be provided a drink and a specific snack.

As such, resident #004 was not provided care as per the plan of care regarding food and fluid dietary requirements. (log #011377-18) [s. 6. (7)]

2. The licensee has failed to ensure that the care for resident #007 was provided to the resident as specified in the plan.

Inspector #593 observed several meal and snack services provided to residents in a specific home area.

During the breakfast meal service May 30, 2019, at 0838 hours, Inspector #593 observed PSW #121 porter resident #004 to the dining room. The resident was leaning to the right of the chair and appeared to be sliding forward and out of the chair. Resident #004 remained in this position until 0906 hours when PSW #121 was observed to reposition the resident.

A review of resident #004's plan of care, found the following:

• I require staff to check hourly while in chair and reposition me when required.

During an interview with Inspector #593 May 30, 2019, PSW #121 indicated that they re-position the resident when they are being toileted which is generally 0730 hours, 0930 hours, 1130 hours and just after lunch.

As such, resident #004 was not provided care as per the plan of care regarding re-positioning. (log #011377-18) [s. 6. (7)]

Issued on this 17th day of June, 2019

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

Original report signed by the inspector.