



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
prévus le Loi de 2007 les
foyers de soins de longue

Health System Accountability and Performance
Division

Performance Improvement and Compliance Branch

Division de la responsabilisation et de la
performance du système de santé

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Mar 8, 9, 20, 21, 23, Apr 3, 5, 10, 2012	2012_036126_0005	Complaint <i>Log # O-000585-12</i>

Licensee/Titulaire de permis

SEASONS RETIREMENT COMMUNITIES (MADONNA LTC) GP
100 Milverton Drive, Suite 300, MISSISSAUGA, ON, L5R-4H1

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

MADONNA LONG-TERM CARE RESIDENCE
1541 St. Joseph's Boulevard, Orleans, ON, K1C-1S9

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

LINDA HARKINS (126)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, the Director of Care, Registered Nurses (RN) and Registered Practical Nurses (RPN) and Personal Support Worker, the Psycho Geriatric Nurse and two Physicians.

During the course of the inspection, the inspector(s) Reviewed the resident health care record, observed care and services provided to resident and reviewed policies and procedures related to skin assessment and abuse.

The following Inspection Protocols were used during this inspection:

Personal Support Services

Responsive Behaviours

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES



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Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 subsections:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,

(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and

(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to revise the plan of care when it has not been effective.

On a specified day in February 2012, a resident was noted to have bruising on the arm and on the left hand. Following that incident, the Home chose to do head to toe skin assessment on the resident immediately after returning from a Leave of Absence (LOA) even if he/she was gone for a few hours. These skin assessments were done by two or more RNs on two occasions and caused much anxiety/agitation to the resident and her family. There is no documentation in the plan of care regarding these modified interventions which were done without clear explanation and expectation to staff and family.

The morning of March 8, 2012, a resident was noted to be incontinent of urine, wearing a pyjama's. At 16:15, that day, the resident was still wearing the same pyjama even after several attempts were made by staff to provide care were unsuccessful.

On March 8, 2012 the RPN stated that the resident has been refusing his/her medications for several days in March 2012. One of the prescribed medication is for pain. By refusing to take this medication, the resident's behavior could be affected by continuing to refuse care.

On March 8, 2012, a resident was observed to refuse to go to the dining room for meals. Nursing staff stated that the resident often refused to eat so they will bring a tray with his/her meal in the bedroom or in the hallway in front of the dining room. The plan of care does not indicate interventions related to the meal time.

Nursing staff interviewed and they stated that they are aware that the resident could stay a full day in the same clothing without receiving care (medications, meal time, bathing, grooming, mouth care and continence care) because he/she is refusing most of the time. The plan of care does not give clear directions to staff to ensure the resident's care needs are met when the resident persistently refuses care offered.



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Issued on this 10th day of April, 2012

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

L. Hawkins