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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 18, 2013	2013_128138_0041	O-000510-13, O-000519-13	Complaint

Licensee/Titulaire de permis

DUNDAS MANOR LIMITED
533 CLARENCE STREET, P.O. BOX 970, WINCHESTER, ON, K0C-2K0

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

DUNDAS MANOR NURSING HOME
533 CLARENCE STREET, P.O. BOX 970, WINCHESTER, ON, K0C-2K0

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

PAULA MACDONALD (138)

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 16 - 17, 2013

An additional purpose of this inspection was for orientation.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Clinical Team Lead, Registered Nurses, a housekeeping staff member, many Personal Care Workers, the Staffing Coordinator, Registered Practical Nurse, and residents.

During the course of the inspection, the inspector(s) reviewed the home's written staffing pattern and call in practices, policies related to Plan of Care and Staffing Plan, the home's Medication Analysis Binder, Pharmacy and Therapeutics meeting minutes, reviewed resident plans of care, and toured the home early am to review morning care practices.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Medication

Sufficient Staffing

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

LTCH Inspector #138 arrived at the home early morning on October 17, 2013 and identified at least nine residents up and dressed for the day prior to 06:00 hours.

LTCH Inspector #138 reviewed the plan of care for several of the residents identified above and observed that the plans of care did not outline resident's sleep patterns and preferences. The inspector then spoke with several personal care workers who stated that any information relating to residents' bed routines should be found in the care plans that were kept in binders at the nursing station. The inspector further reviewed the care plan binders for Unit #1 and Unit #2 and observed that only four of fifty-six care plans had any information relating to resident sleep patterns and preferences and that only one of these contain information relating to resident's preferences for rising in the morning. [s. 26. (3) 21.]

Issued on this 18th day of October, 2013

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