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

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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 9, 2018	2018_617148_0019	013264-18	Resident Quality Inspection

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

AMANDA NIXON (148), LINDA HARKINS (126)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): June 18, 19, 20 and 21, 2018

The following critical incident (CI) inspection was conducted concurrently with the Resident Quality Inspection: Log 003986-18 related to an incident that caused injury to a resident for which the resident is taken to hospital.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, Associate Director of Care, Resident Assessment Instrument (RAI) Coordinator, Activity Director, Personal Support Worker Supervisor, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), family members and residents.

The Inspectors reviewed resident health care records, documents related to the medication management system, resident council meeting minutes, policies and procedures as required and the licensee's investigation documents related to the above identified critical incident. In addition, the Inspectors toured resident care areas in the home and observed infection control practices, medication administration, staff to resident interactions and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

3 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	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 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 set out in the plan of care is provided to the resident as specified in the plan.

During an interview with resident #006, the resident expressed a preference to rise in the morning between 0800-0830 hours. The resident indicated that prior to living at Dundas Manor, the resident would not rise from bed until at least 0900 hours. Further to this, the resident noted that the resident was able to stay in bed on scheduled bath days and this was a pleasure. The resident identified PSW #108 as the staff member who usually provides morning care.

Inspector #148 spoke with PSW #108, who identified as being the PSW who regularly provides resident #006 with morning care. PSW #108 reported that the resident is usually risen between 0700-0730 hours, as the resident does not like to get up earlier than this time. The PSW was aware of the resident's previous life routines, noting that the resident's spouse had reported that the resident enjoys staying in bed until later morning hours.

The plan of care for resident #006 indicates that the resident prefers to get up at 0830 hours. The plan of care for resident #006 is not provided as set out in the plan of care. [s. 6. (7)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident may be restrained by a physical device if the restraining of the resident is included in the resident's plan of care.

Resident #004 was admitted to the home in early 2018 and was observed on June 19 and 20, 2018, to be seated in a wheelchair with a tilt applied. Inspector #148 spoke with PSW staff members #105, #106 and #107, regarding the use of the tilt. Each staff member described the resident as actively attempting to leave the chair, leaning forward, climbing or reaching out of the chair. Both staff members #106 and #107 indicated that the tilt was applied for the resident's safety; specifically PSW #107 indicated that the resident had fallen from the chair. The Inspector reviewed the progress notes which described a fall on a specified date, from the chair.

In review of the health care record, the use of a physical device as a restraint is not included in the resident's plan of care. [s. 31. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to a resident in accordance with the directions for use specified by the prescriber.

1) On a specified date, resident #010 was prescribed two medications. Twelve days after this date, RN #109 reviewed resident #010's health care record and noted that neither medication had been documented on the Medication Administration Record (MAR).

Resident #010 did not received two medications for a twelve day period, in accordance with the directions for use specified by the prescriber.

2) On a specified date, resident #023 was prescribed a new medication and at the same time a medication was discontinued. Twenty days after this date, RPN #110 reviewed resident #023's quarterly medications and noted that the new medication orders of the specified date had not been processed correctly.

Resident #023's did not receive medications in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Issued on this 9th day of July, 2018

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

Original report signed by the inspector.