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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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
Dec 12, 2012	2012_202165_0006	H-000937-12	Complaint

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

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

THE VILLAGE OF WENTWORTH HEIGHTS
1620 UPPER WENTWORTH STREET, HAMILTON, ON, L9B-2W3

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

TAMMY SZYMANOWSKI (165), LISA VINK (168)

Inspection Summary/Résumé de l'inspection

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

---

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

This inspection was conducted on the following date(s): December 4, 5, 6, 2012

This inspection was conducted in conjunction with Inspector Barb Naykalyk-Hunt (146)
Complaint Inspections H-002051-12, H-002190-12

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), House Keeping staff, and Quality Nurse

During the course of the inspection, the inspector(s) Reviewed clinical health records, reviewed policy and procedures and toured the home

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

Nutrition and Hydration

Pain

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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.)	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:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complement each other.
The clinical health record including the Treatment Administration Records (TAR) for resident #4 indicated that on a specified day in 2012 the resident had several open areas. The resident's quarterly assessment and the resident assessment protocol (RAP) completed ten days later indicated the resident's skin was intact despite exhibiting open areas. Staff confirmed that the resident exhibited open areas at this time. [s. 6. (4) (a)]

2. The licensee did not ensure that the staff and others involved in the different aspects of care of resident #4 collaborated with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.
The resident returned from hospital with speech language pathology recommendations for a modified textured diet however; the residents diet order signed by the Physician the following day was a regular/modified regular diet. The resident's plan of care was updated the day after return from hospital and indicated the resident was to receive a modified textured therapeutic diet. [s. 6. (4) (b)]

3. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan of care was no longer necessary. Resident #4 exhibited several open areas and had an identified blackened area. Documentation indicated that upon return to the home from three hospital visits the following month the resident had a stage 4 ulcer and an identified necrotic area however; the resident's plan of care was not reviewed and revised to reflect their changes in skin integrity. The resident's plan of care was last updated prior to hospitalization and did not identify that the resident had any skin impairment. [s. 6. (10) (b)]

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 to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment and development and implementation of the plan of care of the resident so that the assessments are integrated and were consistent with and complement each other and ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan of care was no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee shall ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.
a) Resident #8 was identified in September 2012 to have a blister which required treatment. According to the clinical health record and the TAR this area of altered skin integrity was not reassessed during the month of September 2012.
b) Resident #3 had an order in place to apply treatment creams to reddened areas at least 2 to 3 times a day. According to clinical health records including the TAR these areas of altered skin integrity were not reassessed during the month of September 2012.
Discussions with the RPN and Quality Improvement Nurse confirmed that there was no record of reassessment of these areas of altered skin integrity for residents #8 and #3 for the time frames identified. [s. 50. (2) (b)]

2. The licensee of the long term care home did not ensure that resident #4 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.
The resident had several open areas however; their was no weekly reassessment completed by a member of the registered nursing staff for three consecutive weeks after it was identified. The Quality Improvement nurse confirmed that weekly assessments were not completed during this time period. [s. 50. (2) (b) (iv)]

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 to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Where the Act or this Regulation requires the licensee to have, institute or otherwise put in place, any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.
The home had a system in place which allowed Registered Staff to delegate the responsibility to PSW's of the application of some prescription treatments for residents in specific situations.
The home's policy and procedure "UCP and Delegation of Medication Administration - 04-02-15" directed the PSW who administers a medication or treatment to document correctly in the Medication Administration Record (MAR)or TAR.
The RPN and PSW staff identified that the PSW's were applying treatment creams, as directed under the home's policy, however the Registered Staff were documenting application of the treatment cream on the TAR rather than the individual who provided the treatment. [s. 8. (1)]

2. Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee did not ensure that the plan, policy, protocol, procedure, strategy or system was complied with.
The home did not follow their "Weight and Height Monitoring policy (04-76)". The procedure indicated that when a weight loss or gain of more than 2kg was noted from the previous month the PSW would reweigh the resident immediately to ensure the weight was correct.
a)Resident #4 had a 10.8kg weight loss one month and a 7.5kg weight loss another month however; there was no documented reweigh taken and recorded on both occasions. Staff confirmed that when reweighs are taken they are recorded on the weight monitoring sheet and entered into the computer system.
b) Resident #10 had a 3.4kg weight loss in one month however; there was no documented reweigh taken and recorded. [s. 8. (1) (b)]

3. Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee did not ensure that the plan, policy, protocol, procedure, strategy or system was complied with.
The home did not follow their Weight and Height Monitoring policy (04-76). The procedure indicated that weight would be recorded on re-admission, monthly and as needed.

1. Where the Act or this Regulation requires the licensee to have, institute or otherwis

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's response to interventions are documented.
a) During discussions with resident #3, the front line staff and the Administrator it was identified that a number of situations, actions taken by the home and the residents response to these interventions were not consistently documented.
The Administrator confirmed these omissions of documentation and indicated she was considering maintaining a separate file/log, to record specific information which was not directly related to the care of the resident.
b) The TAR for resident #3 was reviewed for the months of September and October 2012.
These records were noted to contain a number of blank boxes for the prescription treatments which were ordered to be administered on a routine basis.
The RPN and PSW confirmed the blanks on the TAR's however identified that treatments were consistently administered unless, based on assessment it was not required, the treatment was refused, or the resident was not available.
The RPN confirmed that the documentation did not consistently include a record of the interventions completed or rationale why the care was not administered. [s. 30. (1)]

2. The licensee did not ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented. Documentation on resident #4's treatment administration record indicated that treatment was to be initiated on a specific day in 2012 however; treatment was not documented as provided until nine days after. The Quality Improvement Nurse confirmed that treatment should have been documented on the date it was initiated. It was also confirmed that there was no documentation that treatment was provided to the resident on five other days during the same month. [s. 30. (2)]

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

Issued on this 17th day of December, 2012

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

Tammy Szymanowski