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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 11, 2014	2014_267528_0021	H-000687-14	Resident Quality Inspection

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

CYNTHIA DITOMASSO (528), CAROL POLCZ (156), JENNIFER ROBERTS (582)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 9, 10, 11, 12, 13, 16, 17, 18, 19, 2014

This inspection was done concurrently with Critical Incident Inspection log #'s H-000464-14 and H-000600-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Neighbourhood Coordinators, Registered Dietitian (RD), Kinesiologist, Director of Environmental Services, Director of Food Services, registered nursing staff, personal support workers, housekeeping, dietary aides, administration assistance (AA), residents and families.

During the course of the inspection, the inspector(s) observed the provision of care and services, toured the home, reviewed documents including but not limited to: menus and production sheets, staffing schedules, policies and procedures, meeting minutes, clinical health records, and log reports.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care
Trust Accounts

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. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

A. It was identified through observations and an interview with registered staff that resident #15 required two quarter bed rails in the raised position when in bed for positioning. Review of the clinical record did not include an assessment for the use of the bed rails. Interview with registered staff confirmed that there was no formalized assessment completed for the use of bed rails.

B. It was identified through observations and an interview with registered staff that resident #13 required one full bed rail in the raised position when in bed for positioning. Review of the clinical record did not include an assessment for the use of the bed rail. Interview with registered staff confirmed that there was no formalized assessment completed for the use of bed rails.

C. It was identified through observations and an interview with registered staff that resident #14 utilized one full bed rail in the raised position when in bed to reduce fear of falling out of bed. Review of the clinical record for resident #14 did not include an assessment for the use of the bed rail. Interview with registered staff confirmed that there was no formalized assessment completed for the use of bed rails. (582) [s. 15. (1) (a)]

2. The licensee did not ensure that where bed rails are used steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

According to the Administrator, all bed systems in the home were evaluated for potential entrapment zones in 2011. The home was unable to provide an exact date and the results of the evaluation. Interview with the Administrator confirmed that approximately 30 new bed systems have been purchased since 2011 and none of those bed have been tested or monitored for potential zones of entrapment. [s. 15. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the resident's right to have his or her participation in decision-making was respected.

A. Resident #52 was noted to require the assistance of staff to shower twice a week. During a shower in September 2013, resident #52 reported to staff that they did not want their hair to be washed. In an interview with the resident it was identified that the staff continued to wash their hair regardless of the refusal, which upset the resident. Interview with the Administrator and registered staff confirmed that staff was aware that the resident did not want their hair washed, but washed it anyway. The resident's right to decide not to have her hair washed was not respected. [s. 3. (1) 9.]

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 resident's rights to have his or her participation in decision-making is respected, to be implemented voluntarily.

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. (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 did not ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

The plan of care for resident #12 indicated that the resident had upper dentures. During the course of the inspection the dentures were found in the resident's bathroom cupboard. Interview with registered staff and direct care staff confirmed that the resident had not used the dentures for several months. The plan of care did not set out clear directions to the staff and others who provide direct care to the resident in relation to the dentures, as confirmed in an interview with registered staff. [s. 6. (1) (c)]

2. The licensee did not ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A. In September, 2013, the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) continence assessment for resident #21 identified that the resident was incontinent of bladder all or most of the time and continent of bowels, requiring increased assistance; but did not indicate a change in their continence status. The Resident Assessment Protocols (RAPS)for the same assessment period identified that the resident had deteriorated from the previous assessment and was incontinent of both bowels and bladder. Interview with registered staff confirmed that the MDS coding was not consistent with the RAPS, for the continence assessment from September 2013, for the resident. [s. 6. (4) (a)]

3. The licensee did not ensure that the care set out in the plan was provided to the resident as specified in the plan.

A. In March 2014, resident #15 was re-admitted to the home with a new area of altered skin integrity and referred to the Wound Care Specialist for assessment. Review of the plan of care included treatment orders for daily dressing changes. For the month of April 2014, the dressing changes were not documented as completed by registered staff on 25 out of 30 days. Interview with the Wound Care Specialist confirmed that the dressings were not consistently changed as evidenced by the treatment administration records (TARS). [s. 6. (7)]

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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other; and that the care set out in the plan is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the home, furnishings and equipment were kept clean and sanitary.

A. On June 9, 2014 the shower chair in the shower room on Rymal home area was noted to have dried brown debris on the seat. On June 10, 2014, the same shower chair seat was covered with a wet towel, when the towel was removed the same brown debris remained on the seat. On June 17, 2014, the brown debris was less apparent but still present. Interview with direct care staff confirmed that the dried brown substance could be removed with a cloth. The shower chair was not kept clean and sanitary. [s. 15. (2) (a)]

2. The licensee did not ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

A. On June 9, 2014 at 12:30 hours, the spa tub room on Carrington home area was observed to have a ceiling tile removed near the tub with water dripping from the ceiling. Two staff members on the home confirmed that there was water dripping from the ceiling, and that a maintenance staff member was notified. On June 18, 2014, observations of the spa tub room revealed that the ceiling was no longer dripping water.

B. It was noted that tiles were broken/missing in the shower room in the Scottsdale home area. Interview with the Director of Environmental Services on June 16, 2014 identified that the home planned on having the tiles in shower room repaired in July 2014. The Director of Environmental Services reported that this area had been repaired in the past and the home was looking into other options to permanently repair the problem area. (156) [s. 15. (2) (c)]

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 home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the home was equipped with a resident-staff communication and response system that could be easily accessed and used by residents, staff and visitors at all times.

On the first day of the inspection, June 9, 2014, there were five out of seven call bells cords that were observed to be wrapped several times around grab bars in the the bathrooms of Stonechurch secure home area that could not be activated when pulled. On June 17, 2014 at approximately 14:30 hours in the Stonechurch home area, three rooms, had bathroom call bells that did not activate when pulled because the cords were wrapped several times around the grab bars beside the toilets. Interview with registered staff confirmed that the call bells did not activate properly when pulled and that the cords were not to be wrapped around the bars. [s. 17.]

2. The licensee did not ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.

It was noted during the initial tour of the home that the chapel, both accessible to and used by residents, was not equipped with a resident-staff communication and response system. Interview with the Administrator and Director of Environmental Services confirmed that the chapel did not have a call bell. [s. 17. (1) (e)]

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 resident-staff communication and response system:
i. can be easily accessed and used by residents, staff and visitors at all times
ii. is available in every area accessible by residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee did not ensure that each resident received oral care to maintain the integrity of the oral tissue that included the cleaning of dentures.

During observation to inspect call bells, the roommate of resident #12 requested the inspector look at the dentures stored in the shared bathroom. When the inspector looked at the dentures in the cupboard that they were referring to, it was noted that there was mold growing on the top of the liquid containing resident #12's dentures. The dentures were shown to the registered staff who took them away and confirmed that they should have been cleaned. Review of the plan of care for resident #12 identified that staff were to clean the dentures daily. Interview with the Neighbourhood Coordinator confirmed that the dentures were to be cleaned daily. Interview with the Administrator confirmed that the dentures should have been cleaned. [s. 34. (1) (a)]

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 each resident receives oral care to maintain the integrity of the oral tissue, including the cleaning of dentures, to be implemented voluntarily.

WN #7: 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 did not ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered staff, if clinically indicated.

A. Resident #22 was noted to have recurring skin issues. In May 2014, a new area of altered skin integrity was identified by registered staff. Review of the plan of care did not include weekly reassessments by registered staff. Interview with registered staff confirmed that they were unaware of the current status of the altered skin integrity. Interview with the Wound Care Consultant confirmed that due to the resident's high risk for altered skin integrity, weekly assessments were clinically appropriate. [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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered staff, if clinically indicated, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee did not ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes evaluated.

A. In September 2013, the RAP completed by the RD identified that resident #30's food intake was supplemented with a supplement which was taken well. In December 2013, the RD increased the order of the supplement for the resident and seven days later discontinued the supplement because the resident was not consuming the increased portion and no supplement was trialed. In December 2013, the resident had a recorded weight of 47.9 kg. Later in December 2013, the RD changed the resident to half portions noting that the resident was not eating meals, and the supplement remained discontinued. In January 2014, the RD noted the residents new recorded weight of 46.5 kg as being stable for four months.

In February 2014, the resident's recorded weight was 40.8 kg which represented a weight loss of 5.7 kg in one month. Approximately two weeks later, the RD received a referral regarding the resident's decrease in weight but suspected that it was an error with the scale and identified that it would be followed up in March. In March 2014, the weight was recorded as 41.1kg and the resident was seen by the RD in April 2014, who reported that the resident's weight was stable for the past two months. Actions were not taken and outcomes evaluated with regards to the weight loss of 4.7 kg in February 2014.

The recorded weight in May 2014, was 40.0 kg. The RAP completed by the RD in

May 2014, indicated that the resident's weight was stable and the resident was changed to moderate nutritional risk. The resident's weight continued to decline and was recorded as 39.5 kg in June 2014, a weight change of 17.5 percent over six months. The trial of no supplement from December 2013, was not followed up on. Interview with the RD confirmed that actions were not taken to address the weight decline and outcomes were not evaluated.

B. In April 2014, resident #15 had a recorded weight of 60 kg. After the recorded weight in June 2014, it was noted that the RD discontinued the supplement, noting the resident was refusing. In May 2014, the recorded weight for the resident was 49 kg and a further decline to 47.5 kg was noted in June 2014, a total weight change of 20.8 percent over two months. A referral was made to the RD related to the weight loss in May 2014, however, no action was taken and outcomes were not evaluated as confirmed by the DOC on June 19, 2014. [s. 69. 1.]

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 with significant weight loss are assessed using an interdisciplinary approach, and that action are taken and outcomes evaluated, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances were labeled properly and kept inaccessible to residents at all times.

A. During the initial tour on June 9, 2014 at approximately 10:15 hours, it was noted that the Dirty Utility room in Rymal home area was unlocked and the door was wide open. Interview with direct care staff, at that time, confirmed that the door should be shut and locked. Two biohazardous stericycle bins and three chemicals (cleaner and disinfectant, odour and stain remover, and Virex) were found on the counter. The two stericycle bins contained disposable razors, however, the lid to one of the bins popped off when the bin was moved exposing a needle inside the bin as well. The Inspector shut and locked the door when they left the area.

B. During the initial tour on June 9, 2014 at approximately 10:30 hours, it was noted that the Dirty Utility room door in Carrington Home Area was also open 1" and unlocked. Three stericycle bins were found on counter along with two bottles of disinfectant. The bins contained disposable razors only. The Inspector shut and locked the door when they left the area. [s. 91.]

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 all hazardous substances are labeled properly and kept inaccessible to residents at all times, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee did not ensure that all staff participated in the implementation of the program.

A. The home's "Hand Hygiene Policy 06-13, last revised April 2014", identified four moments of hand hygiene including; before you have contact with residents and their environment, before aseptic procedures, after body exposure risk, and after resident or environmental contact.

In June 2014, observed medication administration on Scottsdale home area. From 7:15 to 7:40 hours, the registered staff administered oral medication and subcutaneous insulin injections to two different residents. Hand hygiene was not completed at any time during the observation. [s. 229. (4)]

2. The licensee did not ensure that there was access to point-of-care hand hygiene agents.

A. During the course of the inspection, hand hygiene agents were not available at point of care in all residents rooms. Direct care staff were noted to be providing care in shared resident rooms and using hallway hand hygiene agents when leaving the room. One to three hand hygiene agents were available in the hallways of each home area, at nursing stations, and on treatment/medication carts. Interview with direct care and registered staff confirmed that they were to use the hand hygiene products in the hallway, at the nursing station, or on the medication/treatment carts. Interview with the Administrator confirmed that hand hygiene agents were not yet installed at point of care in the residents rooms, and therefore were not accessible. Administrator also confirmed that staff did not carry around hand hygiene products in their pockets and a plan was in place to install hand hygiene agents in all residents rooms. [s. 229. (9)]

3. The licensee did not ensure that each resident admitted to the home was screened for tuberculosis within 14 days of admission, unless the resident had already been screened at some time in the 90 days prior to admission and the documented results of the screening were available.

A. Residents #41, #42 and #43 were admitted to the home in 2014. A review of their immunization records did not include tuberculosis within 14 days of admission, nor was there documentation to indicate that these residents had been screened 90 days prior to admission. Interview with the home's Infection Control Lead confirmed that tuberculosis screening had not been completed within 14 days of admission for all three residents. [s. 229. (10) 1.]

4. The licensee did not ensure that residents are offered immunizations against pneumoccocus, tetanus and diptheria in accordance with the publicly funded immunization schedules.

A. Residents #41, #42 and #43 were admitted to the home in 2014. A review of their immunization records did not include documentation to suggest that pneumococcal, tetanus and diptheria vaccines had been offered to the residents. Interview with the home's Infection Control Lead confirmed that these immunizations had not been offered to all three residents in accordance with the publicly funded schedules. [s. 229. (10) 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 to ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents., to be implemented voluntarily.

WN #11: 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. The licensee did not ensure that any plan, policy, protocol, procedure, strategy or system put in place is complied with.

A. The home's "Financial Policy - Resident Trust Accounts last reviewed August 2013," outlined that each resident's separate balance will be maintained and a monthly statement will be given to each resident/representative, including a monthly activity balance. The Power of Attorney (POA) for resident #21 identified that they were not receiving monthly account/activity statements. Interview with the Administrator Coordinator confirmed that the home was no longer providing monthly account statements as outlined in the policy, however would be provided on request. [s. 8. (1) (b)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee did not ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A. The plan of care for resident #17 identified that they preferred tub baths. Interview with the the resident and their family confirmed that the resident preferred to have a tub bath, however staff often assisted the resident to the shower instead. In June 2014, the resident was assisted by staff with bathing, as per schedule. Interview with two direct care staff confirmed that they were offered and provided a shower, not a tub bath. [s. 33. (1)]

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a PASD described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

A. It was identified through observation in June 2014, that resident #13 had a full bed rail in the raised position. Interview with registered staff identified that the resident required a full bed rail in the raised position when in bed for positioning. Review of the clinical record did not include the use of the full bed rail or rationale. Interview with the RAI coordinator confirmed that the use of the full bed rail was not in the plan of care.

B. It was identified through observation in June 2014, that resident #15 had two quarter bed rails in the raised position. Interview with registered staff identified that the resident required the bed rails in the raised position when in bed for positioning. Review of the clinical record did not include the use of the full bed rail or rationale. Interview with the RAI-MDS Coordinator confirmed that the use of the bed rails was not in the plan of care. [s. 33. (3)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee did not ensure that when a resident had fallen, that the resident had been assessed.

Resident #13 had a fall as noted in the progress notes in May 2014. Review of the plan of care did not include a post-falls assessment, immediately following the fall. As confirmed by the Neighbourhood Coordinator and by the DOC in June 2014, the resident was not assessed after the fall. [s. 49. (2)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (2) The licensee shall ensure that each menu,
(a) provides for adequate nutrients, fibre and energy for the residents based on the current Dietary Reference Intakes (DRIs) established in the reports overseen by the United States National Academies and published by National Academy Press, as they may exist from time to time; and O. Reg. 79/10, s. 71 (2).

Findings/Faits saillants :

1. The licensee did not ensure that each menu provided for adequate nutrients, fibre and energy for the residents based on the current Dietary Reference Intakes (DRIs) established in the reports overseen by the United States National Academies and published by National Academy Press, as they may exist from time to time.

A. On June 9, 2014, the therapeutic menu indicated that a #8 scoop was to be used for citrus salad, however, a #30 scoop was used instead. A #8 scoop was indicated for dill potato salad, however, a #10 scoop was used instead. The menu indicated that a #12 scoop was to be used for minced citrus salad, however, a # 8 scoop was used instead. The alternative scoop sizes used did not ensure that residents received adequate nutrients, fibre and energy according to the therapeutic menu.

B. On June 16, 2014, during the observed lunch service, a #10 scoop was indicated for minced and puree carrot coins and minced Waldorf salad, however, a #12 scoop was used instead for these items. The therapeutic menu indicated that a grilled cheese sandwich was suitable for those on a minced textured diet, however, the home prepared a minced grilled cheese sandwich instead. A #8 scoop was indicated for puree grilled cheese sandwich, however, a #12 scoop was used instead. The alternative scoop sizes used did not ensure that residents received adequate nutrients, fibre and energy according to the therapeutic menu. (156) [s. 71. (2) (a)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

**s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).**

**s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).**

Findings/Faits saillants :

1. The licensee failed to ensure that the standardized recipes were followed. Recipes were not always followed as confirmed by the Director of Food Services on June 18, 2014.

A. The posted menu on one home area in June 2014, indicated that spinach citrus salad would be served. During the observed meal service, citrus salad consisting of pineapple and oranges was served; there was no spinach in the salad. As confirmed with the Director of Food Services on June 18, 2014, the recipe ingredients were romaine lettuce, spinach, and orange mandarin dressing.

B. During the observed lunch meal on one home area in June 2014, the dietary aide reported that the puree salmon and puree bread were served separately. The recipe, however, indicated that the whole sandwich was to be pureed together. Interview with the Director of Food Services confirmed that the recipe was not followed.

C. During the lunch meal on one home area in June 2014, the recipe for puree hot dog and puree hamburger indicated that the whole hotdog or hamburger including the bun was to be prepared together. The dietary aide confirmed that the puree hotdog and puree hamburger were served with puree bread and that the filing was prepared separately. Interview with the Director of Food Services confirmed that the recipe was not followed.
[s. 72. (2) (c)]

2. The licensee failed to ensure that all menu items were prepared according to the planned menu.

A. On June 9, 2014, the therapeutic menu indicated that creamy tomato soup was to be provided, however, the home provided cream of mushroom soup instead. The therapeutic menu indicated that marinated cucumbers were to be prepared for those on a regular textured diet. The menu indicated that minced and puree peas were to be prepared for those on textured diets, however, minced and puree marinated cucumbers were prepared instead. [s. 72. (2) (d)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the following requirements were met where a resident is being restrained by a physical device under section 31 of the Act, that the staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.

A) A review of the health care record for resident #19 revealed that in June 2014 the lap belt restraint was discontinued as per the physician's order, however the PSW flow sheets indicated that the lap belt had been applied to the resident while in the wheelchair daily for approximately eight days following the order. The resident was observed to have the lap belt applied while in the wheelchair on two days during the inspection. A member of the registered staff confirmed that the lap belt was applied on these days even though there was no order for the restraint. [s. 110. (2) 1.]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2014_247508_0005	528

Issued on this 24th day of July, 2014

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CYNTHIA DITOMASSO (528), CAROL POLCZ (156), JENNIFER ROBERTS (582)
Inspection No. / No de l'inspection :	2014_267528_0021
Log No. / Registre no:	H-000687-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 11, 2014
Licensee / Titulaire de permis :	OAKWOOD RETIREMENT COMMUNITIES INC. 325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	THE VILLAGE OF WENTWORTH HEIGHTS 1620 UPPER WENTWORTH STREET, HAMILTON, ON, L9B-2W3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	VANDA KOUKOUNAKIS

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

To OAKWOOD RETIREMENT COMMUNITIES INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall ensure that where bed rails are used steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Grounds / Motifs :

1. The licensee did not ensure that where bed rails are used steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

According to the Administrator, all bed systems in the home were evaluated for potential entrapment zones in 2011. The home was unable to provide an exact date and the records/results of the evaluation. Interview with the Administrator confirmed that approximately 30 new bed systems have been purchased since 2011 and none of those bed have been tested or monitored for potential zones of entrapment. (528)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 15, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 11th day of July, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cynthia DiTomasso

Service Area Office /
Bureau régional de services : Hamilton Service Area Office