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

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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
Feb 12, 2014	2014_225126_0002	O-000002-14, O-000847-13	Complaint

Licensee/Titulaire de permis

DEEM MANAGEMENT LIMITED
2 QUEEN STREET EAST, SUITE 1500, TORONTO, ON, M5C-3G5

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

WELLINGTON HOUSE NURSING HOME
990 EDWARD STREET NORTH, P.O. BOX 1510, PRESCOTT, ON, K0E-1T0

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.

This inspection was conducted on the following date(s): January 29-31, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, one Registered Nurse, several Registered Practical Nurses, several Personal Support Workers

During the course of the inspection, the inspector(s) reviewed two resident health care records and observed care and services given to residents.

The following Inspection Protocols were used during this inspection:

Hospitalization and Death
Nutrition and Hydration
Responsive Behaviours
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.) 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. 141. Licensee to stay in contact

Specifically failed to comply with the following:

s. 141. (1) Every licensee of a long-term care home shall maintain contact with a resident who is on a medical absence or psychiatric absence or with the resident's health care provider in order to determine when the resident will be returning to the home. O. Reg. 79/10, s. 141 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s.141. (1) in that the licensee did not maintain contact with the health care provider while resident #1 was on a psychiatric absence and resident #3 was on a medical absence.

In the progress notes of a specific day in August 2013, Resident #1 was admitted to a local hospital for the management of responsive behaviors. On that same date, the Psycho Geriatric nurse called the home to informed them that Resident #1 would be admitted to an out of town hospital when a bed became available.

The next progress note related to resident #1 hospitalization was on a specific day in September 2013 when the family member informed the home that Resident #1 was admitted to the out of town hospital.

In four progress notes of specific day in September and October 2013 it was indicated that "resident remains in hospital". Resident #1 was discharge from the home on a specific day in October 2013.

Interview with the Director of Care and the Administrator and they indicated that they did not maintain contact with the out of town hospital while Resident #1 was on a psychiatric absence. [s. 141. (1)]

2. Resident # 3 was admitted to the hospital on a specific day in May 2013. In the progress notes of the evening of a specific day in May 2013, it was documented that Resident #3 "remains in hospital". The next documentation is on the following day when Resident #3 returned to the home from hospital.

Interviewed with Nursing Staff # 100 and S#101, both working full time day shift, indicated that usually they call the hospital on a regular basis and document about the resident condition and anticipated discharge in the progress notes.

The home did not maintain contact with the resident or health care provided during the medical absence. [s. 141. (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 the licensee maintain contact with the health care provider when on a medical absence or psychiatric absence., to be implemented voluntarily.

Issued on this 12th day of February, 2014

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