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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 16, 2015	2015_330573_0022	O-002382-15	Resident Quality Inspection

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

ANANDRAJ NATARAJAN (573), KATHLEEN SMID (161), RENA BOWEN (549)

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): August 31, 2015, September 1, 2, 3, 4, 8, 9, 10 and 11, 2015

Critical Incident Inspection Log # O- 002454-15 was also inspected during the Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Rai- Coordinator, the Maintenance Manager, the Environmental Service Manager, the Office Manager, the National policy and performance improvement consultant, Registered Nurses, Registered Practical Nurses, Personal Support Workers, two Activity staffs, the President of the Resident Council, the President of the Family Council, several residents and several family members.

During the course of the inspection, the inspector(s) completed a walk through tour of all resident areas, observed medication storage areas, observed resident care, observed meal services, observed medication administration, reviewed resident health records, minutes of Resident's and Family Council, home internal investigation documents, reviewed relevant home policies, protocol and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 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. (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 has failed to 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 care set out in the plan has not been effective.

On three specified dates in September 2015 Inspector #573 observed that Resident #17's fingernails of both hands were long, untrimmed and unclean with dirt underneath the nails.

Inspector reviewed Resident #17's written plan of care in effect which identifies that Resident requires one staff extensive assistance for personal hygiene. The plan of care further indicates that Resident #17 is resistive to personal care and noted interventions for resistive behaviours.

On September 9, 2015, Inspector #573 reviewed the Resident #17's health care record and noted several progress notes outlining that Resident #17 refused care and services related to personal hygiene, showers, pericare, blood pressure monitoring and lab work.

Inspector spoke with PSW S#118 who indicated that Resident #17 fingernails were to be cleaned and trimmed by staffs on the shower days and further indicated that it is not possible for staffs to provide finger nail care due to resident resistive behaviours. PSW S#118 also indicated that it is often a challenge for PSW staffs to provide pericare or shower to the resident.

On September 9, 2015 Inspector spoke with the RN S#109 who indicated that Resident #17's current plan of care for resistive behaviours is not effective and further indicated that lately resident was not re-assessed and no actions were taken to try different approaches for the Residents #17's responsive behaviours. [s. 6. (10) (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 Resident #17 is reassessed and the plan of care for responsive behaviours reviewed and revised at any other time when care set out in the plan has not been effective., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's zero tolerance of abuse and neglect policy contains an explanation of the duty under section 24 of the Act to make mandatory reports.

On September 8, 2015 Inspector #549 reviewed Extendicare Canada Inc. Resident Abuse Policy # OPER-02-02-04 version date November 2013. A review of the policy indicated that the policy did not contain an explanation of the duty under section 24 of the Act to make mandatory reports for the following requirements:
1. Improper or incompetent treatment of care of a resident that resulted in harm or risk of harm to resident
2. Unlawful conduct that resulted in harm or a risk of harm to a resident
3. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006

Inspection # 2015_348143_0006 was conducted in January 2015 which indicated that Extendicare Canada Inc. has a revised draft abuse policy in place with a version date of January 2015 which contained an explanation of all the requirements under section 24 of the Act.

It was indicated to Inspector #549 during an interview with the Administrator and Extendicare National Policy and Performance Improvement Consultant that the most recent version of the Resident Abuse Policy # OPER-02-02-04 is the November 2013 version.

On September 10, 2015 the Administrator provided Inspector #549 with a written revised Extendicare Canada Inc. Resident Abuse Policy # OPER-02-02-04 version date September 2015 which includes the required explanation of the duty under section 24 of the Act to make mandatory reports. [s. 20. (2)]

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's zero tolerance of abuse and neglect policy contains an explanation of the duty under section 24 of the Act to make mandatory reports., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The Licensee failed to ensure that, for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, strategies are developed and implemented to respond to these behaviours, where possible.

On a specific day Inspector #161 interviewed Resident #33 and indicated that she/he had concerns regarding Resident #44's ongoing spitting behaviours in the dining room. The Resident #33 further indicated that the home's management had transferred Resident #44 to another table however, the Resident was still spitting in the dining room.

The minutes of Resident's Council on a specific month in 2015 were reviewed by Inspector #161 and #573 and indicated that the President of Resident's Council as well as three other Residents were concerned about Resident #44's spitting behaviour in the dining room, physical aggression with co-residents and verbal outbursts.

Resident #44 has a medical diagnosis of cognitive impairment. A review of the Resident's progress notes indicated numerous entries of Resident #44 spitting behaviour in the dining room during meal times, physical aggression with co-residents and staffs, verbal outburst and refusing care.

Inspector reviewed the Resident #44's health care records for three specific months in 2015. It was noted that no behavioural triggers for Resident #44 spitting in the dining room, physical aggression with co-residents and staffs, verbal outbursts and refusing care were identified. Further the current written plan of care for Resident #44 did not identify any strategies that was developed and implemented to respond to these responsive behaviours. [s. 53. (4) (a)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

1. The Licensee failed to ensure that drugs must be destroyed by a team acting together and composed of, when the drug is not a controlled substance, one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and one other staff member appointed by the Director of Nursing and Personal Care. For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable.

On September 8, 2015 at 14:00 hours, Inspectors #161 and #549 observed in the home's medication room, a lidless, white plastic disposal Stericycle receptacle which contained a large number of drugs that had not been destroyed including anti psychotic and antidepressant tablets. Both the home's Administrator and Director of Care, who observed same, indicated to Inspectors #161 and #549 that these drugs should have been destroyed by two Registered Staff members. They further indicated that they would immediately put a plan in place to rectify this issue. [s. 136. (3) (b)]

Issued on this 16th day of September, 2015

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

Original report signed by the inspector.