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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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
Aug 14, 2013	2013_184124_0013	O-384-13, O-439-13, O-443-13	Critical Incident System

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

LYNDA HAMILTON (124)

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): July 16-19 and 22-26, 2013

This inspection included the following log numbers and related Critical Incident Reports:
O-000384-13(CI 2807-000016-13), O-000439-13(CI 2807-000021-13), O-000443-13 (CIs 2807-000022-13, 2708-000030-13), O-000556-13(CI 2807-000027-13) and O-000591-13(CI 2807-000024-13).

During the course of the inspection, the inspector(s) spoke with Residents, the Administrator, Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers and a Registered Nurse with the Psycho-Geriatric Outreach Team.

During the course of the inspection, the inspector(s) completed walking tours of the home, observed staff-resident interactions, made general observations regarding resident care, reviewed resident health care records and the home's policy, CLIN-09-03-04F "First Aid Following a Resident Fall".

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Falls Prevention

Responsive Behaviours

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 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to comply with the LTCHA 2007, s. 3.(1)8. whereby Resident #8 and #9's right to be afforded privacy in caring for their personal needs were not fully respected and promoted.

Resident #9 is a wheelchair dependent resident who is transferred by mechanical lift.

On July 13, 2013 at 13:45 hours, inspector 124 was walking by a specified room and observed Resident #9 being transferred by mechanical lift into bed. Resident #9's leg to the top of the thigh was exposed.

Resident #9's bedroom door was open and the privacy curtain was not pulled closed. [s. 3. (1) 8.]

2. On July 23, 2013 at 14:55 hours, inspector 124 was doing a walking tour of the home and observed that Resident #8 was in bed, staff were providing personal care and the resident's leg and part of the continence brief were visible from the hallway.

Resident #8's bedroom door was open and the privacy curtain had been partially closed, however the privacy curtain did not afford Resident #8 privacy. [s. 3. (1) 8.]

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 residents' right to be afforded privacy during treatments and in caring for his or her personal needs is fully respected and promoted, to be implemented voluntarily.

WN #2: 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 comply with O. Reg 79/10, s.53.(4)(a) whereby behavioural triggers have not been identified for the responsive behaviours of Resident #3.

Review of Resident #3's progress notes from June 1, 2013-July 25, 2013 was completed and the following was documented:

-Five incidents of verbal aggression toward residents and six incidents of verbal aggression towards staff, described as "yelling and using foul language", "very aggressive, agitated, would not settle, shouting obscenities" and

-Two incidents of physical aggression toward residents and one incident of physical aggression toward staff, described as "defensive with a resident who was headed into Resident #3's room, and "very aggressive, agitated, would not settle, shouting obscenities, slapping, trying to kick".

Staff #106 confirmed that Resident #3 has been both verbally and physically aggressive during provision of personal care.

The Behavioural Support Services Southeastern Ontario Mobile Response Team Initial Collaborative Plan dated July 6, 2013 for Resident #3 identified that the resident has responsive behaviours. The strategies/interventions listed in the initial plan are related to assessment (observation, interaction, redirection) in an effort to identify Resident #3's behavioural triggers.

Resident #3's plan of care does not identify behavioural triggers for the resident's responsive behaviours of verbal and physical aggression. [s. 53. (4) (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 Resident #3's plan of care includes behavioural triggers for the responsive behaviours of verbal and physical aggression, to be implemented voluntarily.

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 14th day of August, 2013

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

Linda Hamilton Reg N