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

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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
Sep 29, 2014	2014_214146_0017	H-001190-14	Resident Quality Inspection

Licensee/Titulaire de permis

HALTON HEALTHCARE LTC INC.
327 REYNOLDS STREET, OAKVILLE, ON, L6J-3L7

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

WYNDHAM MANOR LONG TERM CARE CENTRE
291 REYNOLDS STREET, OAKVILLE, ON, L6J-3L5

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

BARBARA NAYKALYK-HUNT (146), JESSICA PALADINO (586), LESLEY EDWARDS (506)

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): September 10, 11, 15, 16, 17, 18, 2014

This inspection was conducted concurrently with Follow-Up Inspections H-0001181-14, H-0001182-14, H-0001183-14, H-0001184-14, H-0001185-14, H-0001186-14, H-0001187-14 and Critical Incident H-001226-14

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Dietitian (RD), Food Service Manager (FSM), Program Manager, Office Manager, registered staff, housekeeping staff, environmental staff, dietary staff, Personal Support Workers (PSW's), residents and family members.

During the course of the inspection, the inspector(s) toured the home, observed residents, reviewed resident health records, meeting minutes, policies and procedures, schedules and education records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 failed to ensure that the care set out in a resident's plan of care was based on the needs and preferences of that resident.

Observation and interview with a resident confirmed that a resident had a preference related to dining, which the RD confirmed. The resident's plan of care did not indicate the resident's needs and preferences related to dining. The resident's current plan of care is not based on the resident's needs and preferences. [s. 6. (2)]

2. The licensee has failed to ensure that care set out in the plan of care was provided as specified in the plan.

A) A resident's plan of care directed staff to have a specific intervention used to decrease the chance of injury. On a date in July 2014, the health record indicated that the resident did not have the intervention in use. An injury was diagnosed two weeks later that may or may not have been a result of the missed intervention. This information was confirmed by the health record, the DOC and the ADOC.

B) A resident's plan of care directed that the resident must be monitored closely during certain time periods. In September 2014, the resident was observed sitting unmonitored during one of the time periods. The staff confirmed that the resident should have been closely monitored. The resident was not closely monitored as specified in the plan of care. (586)

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. 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 failed to ensure that all dining rooms were kept clean and sanitary.

In September 2014, during an interview with a family member, concern was voiced that a specific dining room did not appear to be cleaned appropriately between meals. Specifically, the family member stated at lunch time, there would often be crumbs, liquid, and sticky residue left on the tables from the meal prior. Observation on a date in September 2014 at 1145 hours, between breakfast and lunch, confirmed that there was food debris on the floor beneath two of the dining tables in the dining room, as well as food debris on table #7 and sticky residue on table #1 in another dining room. There were several pieces of fruit observed on the floor beside table #4 in another dining room with a large number of ants crawling on and around it. The fruit and ants were still present at approximately 1230 hours while a resident was sitting at the table consuming lunch, with their wheelchair right beside the insects. This was brought to the attention of the staff by the inspector. [s. 15. (2) (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 the home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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. 1. 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.

A) The home has a monthly restraint flow sheet which nursing staff are expected to sign every hour that they have visually checked the resident for comfort, positioning and that the restraint is appropriately applied.
(i) Of four months of forms reviewed for a resident, the following was revealed:
June 2014 - there were 25 shifts where the nursing staff failed to document from 1500 hours to 1900 hours;
July 2014 - there were 4 shifts where the nursing staff failed to document;
August 2014 - there were 28 shifts where the nursing staff failed to document from 1500 hours to 1900 hours;
September 2014 - there were 15 shifts where the nursing staff failed to document from 1500 to 1900 hours.
(ii) Of three months of forms reviewed for another resident, the following was revealed:
July 2014 - there were 18 shifts where the nursing staff failed to document from 1500-1900 hours;
August 2014 - there were 4 shifts where the nurse failed to document;
September 2014- there were 15 shifts where the nursing staff failed to document from 1500-1900 hours;
This information was confirmed by the registered staff and the DOC. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee did not ensure that a specific home area provided a safe and secure environment for residents.

A) In September 2014 in a resident room the inspector observed that the maintenance tool cart had been left in the resident's washroom unattended on two occasions over a two hour period and the bedroom door to the hallway was left opened. The resident who resided in the room was off the unit; however, during the second observation the resident was back on the unit. The toilet was being replaced and there were tools all over the floor, empty boxes and the two toilets. The tool cart contained items such as a hammer, mallet, chemicals, paint and other tools. The RPN on the unit confirmed that the maintenance tool cart was not to be left unattended in a resident's room and should have been locked up.

B)In September 2014, approximately nine metal wheelchair footrests were observed stacked in a pile on the floor in the hallway of the home's secure unit and accessible to residents. Cognitively impaired residents were wandering the hallway of the unit. Staff agreed that the footrests could be used by a resident to harm others and should have been stored in the storage room. (586) [s. 5.]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 61. Family Council assistant

Specifically failed to comply with the following:

s. 61. (1) If the Family Council so requests, the licensee shall appoint a Family Council assistant who is acceptable to that Council to assist the Family Council. 2007, c. 8, s. 61. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an assistant to Family Council was appointed to assist the Council when one was requested.
Family Council chair stated that the Council requested an staff liaison to assist the Council with minutes and posting notices approximately a year and a half ago. The Chair was told by the home that there was no one to help and it was not the role of the home to provide an assistant. [s. 61. (1)]

WN #6: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.
A) The following were observed:
i) In September 2014 two unlabelled used combs with hair in them and one unlabelled used roll-on deodorant on a shelf in the common bathing room on one unit. (146)
ii) In September 2014 unlabelled and used toothbrushes in shared bathrooms in four rooms.
iii) In September 2014 the spa room on one home area had an unlabelled roll on deodorant that was used, and a hairbrush that was noted to have hair on it.
iv) In September 2014 the spa room on another home area had an unlabelled hairbrush that was used and had hair on it.
v) In September 2014, an unlabelled personal electric shaver was observed in the shared bathroom between two rooms. (586)
The ADOC confirmed that all personal items are to be labelled (506)

B) During an observation of a medication pass in September 2014, the registered nursing staff did not complete hand hygiene between residents during the medication pass. The registered nursing staff administered an injection to a resident and then proceeded to give oral medications to another resident without washing their hands or using point of care hand hygiene agents. (506) [s. 229. (4)]

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. 19. (1)	CO #002	2014_205129_0002	146
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #003	2014_205129_0001	146
O.Reg 79/10 s. 26. (3)	CO #005	2014_205129_0001	146
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2014_205129_0002	146
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #002	2014_205129_0001	146
O.Reg 79/10 s. 89. (1)	CO #004	2014_205129_0001	146

Issued on this 2nd day of October, 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) :	BARBARA NAYKALYK-HUNT (146), JESSICA PALADINO (586), LESLEY EDWARDS (506)
Inspection No. / No de l'inspection :	2014_214146_0017
Log No. / Registre no:	H-001190-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 29, 2014
Licensee / Titulaire de permis :	HALTON HEALTHCARE LTC INC. 327 REYNOLDS STREET, OAKVILLE, ON, L6J-3L7
LTC Home / Foyer de SLD :	WYNDHAM MANOR LONG TERM CARE CENTRE 291 REYNOLDS STREET, OAKVILLE, ON, L6J-3L5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Stephanie Zajczenko-Opdam

To HALTON HEALTHCARE LTC 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)

Linked to Existing Order / Lien vers ordre existant: 2014_205129_0001, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care is provided to every resident as specified in the plan.

Grounds / Motifs :

1. Previously issued: VPC August 2012 (RQI); VPC October 2012; and CO January 2014.

The licensee has failed to ensure that care set out in the plan of care was provided as specified in the plan.

A) A resident 's plan of care directed staff to have a specific intervention used to decrease the chance of injury. On a date in July 2014, the health record indicated that the resident did not have the intervention in use. An injury was diagnosed two weeks later that may or may not have been a result of the missed intervention. This information was confirmed by the health record, the DOC and the ADOC.

B) A resident's plan of care directed that the resident must be monitored closely during certain time periods. In September 2014, the resident was observed sitting unmonitored during one of the time periods. The staff confirmed that the resident should have been closely monitored. The resident was not closely monitored as specified in the plan of care. (586) (146)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 31, 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 29th day of September, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BARBARA NAYKALYK-HUNT

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