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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Jun 29, 2016	2016_210169_0009	013662-16	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

YVONNE WALTON (169), HEATHER PRESTON (640), JESSICA PALADINO (586), JULIEANN HING (649), THERESA MCMILLAN (526)

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 13, 14, 15, 16, 17, 20, 21, 22, 23, 2016

The following inspections were completed with the Resident Quality Inspection:

Critical Incidents: 018039-16, 010774-15, 019089-16, 016765-16 and 03756-15 related to abuse. 03429-14 related to falls, 006724-15 related to abuse and end of life care, 005467-16 related to falls and responsive behaviours.

Complaints: 008771-14 related to admission process, 004007-15 related to supplies, nursing and personal support services, infection control practises, falls and care planning , 010738-15 and 015111-16 related to falls.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Charge Nurses (CN), Office Coordinator, Program Manager (PM), Rai Coordinator (RC), Clerk/Scheduler, Housekeeping Supervisor, Dietary Manager, Maintenance Manager, Social Worker, Physiotherapist (PT), Behaviour Support staff (BS)), Residents and Families.

The inspectors reviewed clinical records, policies, minutes of meetings, observed care areas and dining services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Resident Charges
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **8 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 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 failed to ensure that the home was equipped with a functioning resident-staff communication and response system that when activated clearly indicated where the signal was coming from.

Residents were at risk of not having staff respond to their care needs when their call bells were activated on three different occasions since pagers were confirmed to not be working on one home area.
The home's resident-staff communication and response system included a paging device that, when activated clearly indicated to staff on their pagers where the signal was coming from. The system failed to alert staff on three occasions when triggered where the signal was coming from.
(1) In June 2016, Inspector #169 discovered, one of the PSW pagers was not functional. The RPN #007 advised the computer system had a power outage at around 1000 hours and the paging system did not get reset, resulting in pagers that did not show where the calls were activated.

(2) In June 2016, Inspector # 169 again identified one of the pagers was not working. Maintenance Manager #001 confirmed that the pager was not working and the battery needed to be replaced.

(3) In June 2016, Inspector activated the resident-staff communication and response system. PSW #010 confirmed their pager was not triggered when the call bell was activated. The Maintenance Manger #001 and registered practical nurse # 009 both confirmed that that the pager was not working.

During interview, the Administrator stated that, if a PSW's pager was not functional and their partner left their functioning pager at the nursing station while they went on break, that the remaining staff would not be aware that a resident had activated their call bell.
In interview, the Administrator stated the home does not have a policy on pagers that directs staff how to determine when the battery needs to be replaced. Staff indicated the pagers may beep when the battery is low and has an indicator on the pager that indicates when the battery is low.
During interview, the Administrator confirmed that when the resident-staff communication and response system was activated it did not clearly indicate where the signal was coming from when staff pagers were non-functioning. [s. 17. (1) (f)]

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 ensure that the home is equipped with a resident-staff communication and response system that, (f) clearly indicates when activated where the signal is coming from, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #010 was protected from abuse by staff in the home.
In June, 2016 the resident verbalized they did not feel respected by one staff member. The resident informed the management team. The management team conducted an investigation and it was confirmed abuse did occur. The critical incident was submitted to the Ministry of Health and the employee was terminated. [s. 19. (1)]

2. The licensee has failed to ensure that resident #054 was protected from abuse by PSW #018.
In May, 2015, resident #054 was doing an activity and there was a verbal abuse incident witnessed by staff. The resident became weepy and began to cry. The resident was interviewed. The staff member was terminated. [s. 19. (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 that ensures all residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, 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 ensure that residents' right to be afforded privacy in treatment and in caring for his or her personal needs was not fully respected and promoted.
In June 2016, the inspector was walking through a Home Area when they observed PSW #002 holding the spa room door open with their foot while assisting resident #046 on the toilet. The inspector could see the resident on the toilet with their brief down. Interview with the DOC confirmed the spa room door should have been kept closed and that the resident's right to be afforded privacy during care had not been fully respected since they could be viewed while on the toilet. [s. 3. (1) 8.]

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 failed to ensure that the resident's substitute-decision maker (SDM) was given the opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #047 used a device while in their wheelchair as a Personal Assistive Services Device (PASD); however, was re-assessed by the PT in March, 2015 and it was deemed that the device was no longer required for the resident, therefore it was removed. Record review and interview with the DOC on June 21, 2016, confirmed that the SDM was not given the opportunity to participate fully in resident #047's plan of care. [s. 6. (5)]

2. The licensee failed to ensure that every resident's plan of care was reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.
Resident #047 used a device while in their wheelchair as a Personal Assistive Services Device (PASD); however, was re-assessed by the PT and it was deemed that the device was no longer required for the resident, therefore it was removed. Review of the resident's documented plan of care identified the use of a device. Interview with the DOC on June 21, 2016, confirmed the resident's plan of care was not updated after their care needs changed. [s. 6. (10) (b)]

WN #5: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.
The home's Medication Management policy labelled "Medication Pass" number CLIN 11-03, last reviewed October 2014, directed staff to "stay with the resident while the resident takes the medication" during a medication pass.
On June 15, 2016, Inspector #169 observed medications at a resident bedside with no registered staff present. The resident was in the bathroom at the time of this observation.

Staff RPN #007 was interviewed and confirmed that they left the medications unattended at the resident's bedside prior to administering them. During interview, the RPN and DOC confirmed that RPN #007 had not followed the home's medication administration policy when they left resident #014's medications unattended in their room without administering them to the resident. [s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy named "Zero Tolerance of Resident Abuse and Neglect Program" RC-02-01-01, updated April 2016, that promotes zero tolerance of abuse and neglect of residents was complied with. In May, 2016 resident #048 was assaulted by another resident. The staff intervened immediately and re-directed the co-resident back to their room and implemented safety interventions to ensure all the resident's safety.

The policy directed staff to "ensure the safety, and provide support of the abuse victim, through completion of full assessments." The registered staff and the DOC confirmed an assessment was not completed post assault.

The policy directed staff to "immediately report to the Administrator/designate/reporting manager". The registered staff and the DOC confirmed the assault was not immediately reported to the on-call manager.

The policy directed staff to disclose the abuse to the substitute decision maker (SDM) immediately upon becoming aware of the incident. The registered staff and the DOC confirmed the assault was not immediately disclosed to resident #048 SDM.
The licensee failed to follow their own policy related to resident abuse. [s. 20. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented for, cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices for supplies and devices, including personal assistance services devices, assistive aids and positioning aids.
The home's "Wheelchair, Assistive Device, Basin & Urinal Cleaning Schedule" for each home area, as well as registered staff #019 and PSW #020, indicated that each resident's wheelchair or walker was to be cleaned weekly as per the schedule by the night shift PSW's.
In June, 2016 on three occasions, resident #039 was observed in their wheelchair with the frame, wheels, and seating pad of the chair to be covered in dried fluid and debris. Review of the home's weekly cleaning schedule identified that the chair was due to be cleaned on night shift; however, four days after the scheduled cleaning, registered staff #019 confirmed the chair was still visibly unclean. [s. 87. (2) (b)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (7) In this section,
"significant change" means a major change in the resident's health condition that,
(a) will not resolve itself without further intervention,
(b) impacts on more than one aspect of the resident's health condition, and
(c) requires an assessment by the interdisciplinary team or a revision to the resident's plan of care.

Findings/Faits saillants :

1. The licensee failed report the incident to the Director within 10 days of becoming aware of the incident, by making a report in writing to the Director.
The interdisciplinary team revised the resident's plan of care due to a significant change in condition. In June 2014, resident #044 had an altercation with another resident, resulting in a transfer to the hospital for assessment. The resident returned from the hospital a few hours later and was re-assessed by the interdisciplinary team based on a significant change in the resident's condition. The Director of Care confirmed a critical incident was not submitted to the Ministry of Health. [s. 107. (7) (c)]

Issued on this 29th day of June, 2016

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

Original report signed by the inspector.