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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 11, 2018	2017_543561_0018	025723-17	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

DARIA TRZOS (561), KELLY HAYES (583), MELODY GRAY (123)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): November 15, 16, 17, 20, 21, 22, 2017.

The following additional inspections were completed during this Resident Quality Inspection (RQI):

Complaint inspection log number:
002303-17 - related to alleged abuse

Critical Incident Report (CIs) inspections with log numbers:
019537-16 - related to alleged abuse
030406-16 - related to alleged neglect
008753-17 - related infection prevention and control

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Acting Director of Care (DOC), Acting Assistant DOC (ADOC), Office Coordinator, Program Manager, RAI Coordinator, Dietary Manager, Maintenance Manager, Physiotherapist, Registered Staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides, Resident Council President, families and residents.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, reviewed documents that included but were not limited to: resident clinical health records, policies and procedures, training records, assessment tools, and program evaluations.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **6 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 has failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

Resident #021 was observed during stage one of this inspection in bed with bed rails applied. PSW #101 was interviewed and stated that resident used bed rails while in bed for transferring and positioning and both rails were not restraints. RPN #100 was interviewed and confirmed that the resident used bed rails while in bed. Resident was not able to get up from bed on their own and the bed rails were not restricting the resident in any way. The written plan of care was reviewed and the use of the bed rails were not included in the written plan of care. RPN #100 confirmed that the bed rails were not included in the written plan of care.

The home's Bed Entrapment and Proper Use of Bedrail Devices policy reference # 08-10 -01, version April 2011 indicated that "the bed system being used by the resident required to be identified in the care plan".

The home failed to ensure that the written plan of care set out the planned care for resident. [s. 6. (1) (a)]

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

An identified resident had a plan of care indicating the staff were required to ensure that the resident could locate the call bell. Resident was observed during inspection and was sitting away from the bed; call bell was not within their reach. PSW #113 confirmed that call bell was required to be placed within reach. The DOC was interviewed and confirmed that the staff were required to place the call bell within resident's reach.
The staff failed to ensure that the care was provided to the resident as specified in the plan. [s. 6. (7)]

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 there is a written plan of care for each resident that sets out the planned care for the resident and to ensure that the care is provided to the resident as specified in the plan of care, to be implemented voluntarily.

WN #2: 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 resident-staff communication and response system that, was available in every area accessible by residents.

During the initial tour of the home, the door to the secure outdoor area in the Trafalgar home area was open. LTCH Inspector went outside and did not observe a resident-staff communication and response system in the secure outdoor area.
The Administrator was interviewed and confirmed that there were no resident-staff communication and response system in the five areas accessible to residents. They also reported that they are in the process of obtaining quotes from the contractor.

The licensee did not ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents. [s. 17. (1) (e)]

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 is equipped with a resident-staff communication and response system that, is available in every area accessible by residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturer's instructions.

The manufacturer's instructions for the identified device were reviewed.

Resident #21 was observed in the wheelchair with an identified device applied incorrectly. PSW #101 who provided direct care to the resident indicated that resident was using this device for safety. PSW indicated that the device was correctly applied and this was how they were taught in school to apply these devices. RPN #100 was interviewed and indicated that resident used this specific device for safety and prevention of falls. RPN #102 indicated that the device was not considered a restraint. Clinical records were reviewed and did not identify the use of this device.

The DOC was interviewed and confirmed that the device was used as an intervention to prevent falls. The DOC confirmed that the requirement was that any such device that was applied had to be correctly applied as per manufacturer's instructions.

The licensee failed to ensure that the staff used all devices in accordance with the manufacturer's instructions. [s. 23.]

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 staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturer's instructions, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care was based on the interdisciplinary assessment of the resident's safety risks.

Resident #021 was observed in the wheelchair with a device applied. PSW #101 was interviewed and stated that resident used this specific device for safety and the resident possibly would be able to remove the device. RPN #102 stated that the device was used as a prevention for falls. LTCH Inspector asked the resident if they could remove the device. Resident was not able to follow direction. The written plan of care was reviewed and did not include the use of the device, there was no assessment of the safety risks found in the plan of care. During observation on an identified date, the device was found to be incorrectly applied. The DOC was interviewed and indicated that the device was used as an intervention to prevent resident from falling and it was not a restraint. The DOC confirmed that the device should have been included in the resident's written plan of care so that staff were aware of the use of this intervention.

The licensee failed to ensure that the plan of care was based on the assessment of the use of the device that could potentially cause a safety risk to the resident. [s. 26. (3) 19.]

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 plan of care is based on the interdisciplinary assessment of the resident's safety risks, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Personal Assistance Services Device (PASD) that was used to assist resident #021 with a routine activity of living was included in the resident's plan of care.

An identified resident was observed using an identified wheelchair during this inspection and staff interviewed indicated that resident was to be positioned to off load pressure related to a skin issue. PSW #113 was interviewed and confirmed that the resident was being positioned to off load pressure related to a skin issue. RPN #100 was interviewed and confirmed that resident was being positioned in their wheelchair for offloading.

Clinical care records were reviewed and indicated that the resident was assessed by the physiotherapist and the assessment indicated that the identified chair was used as a PASD.
The written plan of care and the kardex (a document PSWs use to guide care) did not include the use of the identified chair. RPN confirmed that the identified chair should have been care planned. The ADOC was interviewed and confirmed the same.

The home failed to ensure that the use of the identified chair as PASD was included in the resident's plan of care. [s. 33. (3)]

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 Personal Assistance Services Device (PASD) that is used to assist a resident with a routine activity of living is included in the resident's plan of care, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a dining service that included at a minimum a process to ensure that food service workers and other staff assisting residents were aware of the residents' diets and special needs.

During an observation of the lunch service on an identified date, which started at 1200 hours resident #022 was served part of their meal cut in half and another part of their meal at 1235 hours with no staff present to provide assistance. Approximately five minutes later RPN #107 intervened and shared with that staff the resident was not served the correct diet texture.

The resident was later served another course and at that time PSW #110 provided assistance cutting the meal. The resident refused to eat. The staff did not follow the care plan and the LTCH Inspector notified the RPN #107 at which point they intervened.

Resident #022's dietary profile located in the servery that the Dietary Aide (DA) referenced while serving residents' meals was reviewed. It identified the resident was on an identified diet, including texture modification. No other texture modifications were identified on the sheet.
Resident #022 was assessed by an external specialist on an identified date in 2017. The resident's eating and nutrition care plan identified specific interventions and diet

modifications.

In an interview with DA #112, it was shared that they were aware the resident was on an identified diet; however they were not aware of special modifications and other interventions.

In an interview with PSW #110 on November 20, 2017, it was shared that they were aware the resident was on an identified diet; however, they were not aware of additional modifications and special interventions.

It was observed that PSW #109 was not aware of the resident #022's diet texture or feeding interventions as they served the wrong diet texture and left the food when no staff was available to assist.

In an interview with RPN #107 who was present during the diet service, it was confirmed that the home did not have a process in place during the dining service to ensure that both DA's and PSW's were aware of resident #022's diet and special needs related to feeding. In an interview with the DOC, it was confirmed that two PSW's and DA were not aware of resident #022's diet texture or interventions recommended by the external specialist. It was identified that the interventions were in the resident's care plan but that there was not a process in place during the dining service where staff had access to reference detailed information specific for residents with complex diet orders and feeding interventions. [s. 73. (1) 5.]

2. The licensee has failed to ensure that, residents who required assistance with eating or drinking were served a meal until someone was available to provide the assistance the resident required.

During an observation of the lunch service on an identified date, resident #022 was served an identified meal at 1235 hours. The meal was placed in front of the resident by PSW #109 and no staff were at the table to assist the resident. The resident was capable to feed themselves physically but was observed not take any bites. Approximately five minutes later, RPN #107 intervened and removed the plate sharing with the staff the resident was not served the correct diet texture. The resident was later served a meal and staff provided assistance at 1300 hours, approximately one hour after the service began.

The resident's eating and nutrition care plan identified they were at high risk for choking

and directed staff to monitor the resident closely. Resident #022 required feeding assistance from staff with specific interventions.

In an interview with RPN #107, it was confirmed resident #022 was served a meal before staff were able to provide assistance. In an interview with the DOC, it was verified that resident #022 required a staff member for feeding assistance throughout their meal, due to their risk of choking and the complex feeding techniques that were required for the resident to safely eat. [s. 73. (2) (b)]

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 has a dining service that included at a minimum a process to ensure that food service workers and other staff assisting residents are aware of the residents' diets and special needs and to ensure that residents who require assistance with eating or drinking are served a meal until someone is available to provide the assistance the resident requires, to be implemented voluntarily.

WN #7: 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. (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 there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with.

The home's policy and procedure Jurisdictional Reporting Requirements, #RC-02-01-02 A1, dated April 2016, was reviewed and included: "The LTCHA provides that any person who has reasonable grounds to suspect that any of the following has occurred, or may occur, must immediately report the suspicion and the information upon which it is based to the Director of the Ministry of health and Long-Term Care (the Ministry"). "Abuse of a Resident by anyone or neglect of a Resident by the licensee of staff that resulted in harm or risk of harm to the Resident."

The home's records including investigation record and Critical incident report #2910-000020-16 were reviewed. It was noted that on an identified date in 2016 a family member of resident #025 reported to the home that staff member #122 neglected the resident.

The home did not submit the report to the MOHLTC immediately.

The Administrator was interviewed and confirmed the accuracy of the above information and that the home did not follow its policy and procedure related to immediate reporting of alleged or suspected abuse. [s. 20. (1)]

WN #8: 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. The licensee has failed 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 were documented.

A) The bed of resident #014 was observed with one bed rail raised. PSWs #105 and #106 were interviewed and confirmed the resident required the use of one bed rail when in bed for bed mobility and for transfers.
The record of resident #014 was reviewed and indicated that the resident required the use of one bed rail as above. The Daily Care Flow Sheet Supports Minimum Data Set (MDS) 2.0 Coding used by PSWs was reviewed. There was no documentation in the P4 Devices/Section related to the use of bed rails.
Registered staff #107 was interviewed and confirmed that the resident used the bed rails during this period and that staff monitored their use. They also confirmed that the staff did not document the actions taken with respect to resident #014 related to the use of the bed rail.

B) Resident #021 had a plan of care indicating that they required to be repositioned every two hours while in bed. PSW #113 was interviewed and stated that resident was being repositioned in bed and wheelchair as they had impaired skin integrity. The flow sheets were reviewed for an identified month in 2017 and the care related to every two hour repositioning was not being documented in the flow sheets. PSW confirmed that every two hours was an intervention for resident and it was not being documented as care provided. The ADOC was interviewed and confirmed that care for this resident related to every two hour repositioning while in bed and chair was to be documented. [s. 30. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents who required continence care products had sufficient changes to remain clean, dry and comfortable.

The home's records including Critical Incident report #2910-000020-16 and the investigation records were reviewed. It was noted that on an identified date in 2016 a family member of resident #025 reported to the home that staff member #122 did not provide personal care to the resident. The home immediately initiated an investigation into the concern. The investigation confirmed the events and there were also other incidents noted from the same PSW.
The resident's record was reviewed and the care plan noted that the resident was incontinent, and required the assistance of one staff for continence care.
Resident #025 was observed by LTCH Inspector #561 and no signs of incontinence were observed.

PSW #122 was interviewed during this inspection.

The home's investigation found that PSW #122 did not provide care to resident #025.

The Acting DOC and Administrator were interviewed and confirmed the accuracy of the information in the home's records and the resident's records. They also confirmed that on the day of the incident resident #025 did not have sufficient changes to remain clean, dry and comfortable by PSW #122.

The home failed to ensure that resident #025 who required continence care products had sufficient changes to remain clean, dry and comfortable. [s. 51. (2) (g)]

Issued on this 1st day of February, 2018

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

Original report signed by the inspector.