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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 14, 2019	2019_560632_0001	025121-17, 027673-17, 029451-17, 007551-18	Complaint

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

YULIYA FEDOTOVA (632), DARIA TRZOS (561)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 10, 11, 14, 15, 16, 17, 18, 21, 22, 23, 24, 25, 2019.

The following intakes were completed in this Complaint Inspection:

Log #029451-17 was related to sufficient staffing and personal support services.
Log #025121-17 was related to sufficient staffing.
Log #027673-17 was related to medication.
Log #007551-18 was related to skin and wound care, responsive behaviors and medications.

The following Critical Incident System intake was completed concurrently with this Complaint Inspection:
Log #005258-18 was related to falls management.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Assistant Director of Care, (ADOC), Physician, Office Co-ordinator, Maintenance Manager, Wound Champion, Personal Support Workers (PSWs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), residents and their families.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **5 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	Légende 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that if the plan of care was being revised because care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care.

Complaint log #007551-18 was received by the Ministry of Health and Long-Term Care (MOHLTC) on an identified date in April 2018, reporting that the home failed to provide specified intervention to resident #031.

Review of the plan of care for resident #031 identified that the resident had impaired skin integrity, was at risk and had a history of altered skin integrity.

The written plan of care indicated that resident #031 was at risk and had impaired skin integrity and had specified interventions in place.

The written plan of care did not have specified intervention in place in relation to the management of altered skin integrity as required under O. Reg 79/10, s. 50(2) (d) and (c). The plan of care for resident #031 indicated that the resident required specified intervention and the resident was using a mobility device as their primary mode for locomotion.

On an identified date in April 2018, the progress note indicated that resident #031 had new areas of altered skin integrity and interventions were implemented. Interview with RPN #105 indicated that residents, who were at risk for altered skin integrity, and those that were dependent on staff for specified interventions, were to be get specified interventions by staff. The process in place for the residents, who had an altered skin integrity was to assess the resident, implement specified interventions, monitor the skin for 24 hours and, if not resolved, then resident was to be referred to the Wound

Champion, Registered Dietitian (RD) and follow specified protocol.

There was no evidence documented of when the resident had an altered skin integrity and no documentation found indicative of what interventions were tried to prevent it.

The Wound Champion was interviewed on an identified date in January 2019, and stated that interventions for prevention of altered skin integrity for residents, that were at risk for altered skin integrity, included specified interventions.

The Wound Champion stated that resident #031 was not compliant with the specified interventions.

When clinical records were reviewed, there was no documentation found indicating that resident #031 was not compliant with the specified intervention.

In an interview with RN #100 on an identified date in January 2018, they stated that resident #031 was not compliant with the specified interventions. The registered staff should have tried other intervention for the management of altered skin integrity, since the resident was using their mobility device most of the day. RN #100 confirmed that the written plan of care did not have any other interventions in place to prevent altered skin integrity. New interventions were implemented after the resident developed an altered skin integrity.

The home's Skin and Wound Management program, policy number RC-23-01-01, last revised in February 2017, stated that the program in the home included strong prevention component in the management of altered skin integrity.

The licensee failed to ensure that when the resident was reassessed and the plan of care revised, different approaches had been considered in the revision of the plan of care related to skin and wound. [s. 6. (11) (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 and ensuring that the plan of care is being revised because care set out in the plan has not been effective, the different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: 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 where the Act or this Regulation required the licensee of a long-term care home to have institute or otherwise put in place any policy, the policy was complied with.
O. Reg. 79/10, s. 30 (1) required the licensee to ensure that the written description of the program required under sections 8 to 16 of the Act and each interdisciplinary program required under section 48 of this Regulation, included its goals and objectives and relevant policies, procedures and protocols and provided for methods to reduce risk and monitor outcomes. LTCHA under s. 8 (1) b, requires every licensee of a long-term care home to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

Specifically, staff did not comply with the licensee's protocol titled Nursing Policy Section: Health Care Aide/PSW, Job Routine - 0700-1500 & 0700-1330, 1500-2300 & 1530-2100, 2300-0700 (dated January 2015), which stated that all nurse communication system

device signals were to be answered promptly and kept within reach of the resident. Nurse Call System Policy RC-08-02-01 (last updated in April 2017) directed PSW staff to respond to nurse communication system device signals in a timely and courteous manner.

A. A complaint IL-54696-HA was submitted to the Director on an identified date in December 2017, related to the wait of an identified amount of time for specified interventions for resident #030.

Review of resident #030's written plan of care stated that the resident required specified interventions. Review of Call Point Detailed Activity Report for a period of identified dates in November 2018 up to January 2019, identified nurse communication system signals as specified waiting times for the response initiated by resident #030. Interview on an identified date in January 2019, indicated that the resident usually used their nurse communication system device for specified interventions. On an identified date in January 2019, PSW #103 and PSW #109 indicated that if PSW staff were available, they would answer the nurse communication system device signal right away, if in the middle of care, they answer after the care was provided and resident was safe. On an identified date in January 2019, the ED indicated that depending on situation, the home's expectation about prompt answering on the nurse communication system device signal initiated by a resident was no more than 20 minutes.

The home did not ensure that the Health Care Aide/PSW section of Nursing Policy and Job Routine and Nurse Call system Policy RC-08-02-01 were complied with.

B. Review of resident #039's written plan of care stated that the resident required specified interventions. Review of Call Point Detailed Activity Report for a period of identified dates in December 2018 up to January 2019, identified nurse communication system device signals as specified waiting times for the response initiated by resident #039. Interview on an identified date in January 2019, indicated that the resident usually used their nurse communication system device for transferring to the toilet. On January 16, 2019, PSW #103 and PSW #109 indicated that if PSW staff were available, they will answer the nurse communication system device signal right away, if in the middle of care, they answer after the care was provided and resident was safe. On January 21, 2019, the ED indicated that depending on situation the home's expectation about prompt answering on the nurse communication system device signal initiated by a resident was no more than 20 minutes.

The home did not ensure that the Health Care Aide/PSW section of Nursing Policy and Job Routine and Nurse Call system Policy RC-08-02-01 were complied with.

C. Review of resident #040's written plan of care stated that the resident required specified interventions. Review of Call Point Detailed Activity Report for a period of identified dates in December 2018 up to January 2019, identified nurse communication system device signals as specified waiting times for the response initiated by resident #040. Interview on an identified date in January 2019, indicated that the resident usually used their nurse communication system device for specified interventions. On an identified date in January 2019, PSW #111 indicated that if PSW staff were available, they would answer the nurse communication system device signal right away or within 2-3 minutes. On an identified date in January 2019, the ED indicated that depending on the situation the home's expectation about prompt answering on the nurse communication system device signal initiated by a resident was no more than 20 minutes.

The home did not ensure that Health Care Aide/PSW section of Nursing Policy and Job Routine and Nurse Call system Policy RC-08-02-01 were complied with. [s. 8. (1) (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 and ensuring that where the Act or this Regulation required the licensee of a long-term care home to have institute or otherwise put in place any policy is complied with, 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. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The license failed to ensure that a written record was kept relating to each evaluation under paragraph three that included the date of the evaluation, the names of the persons, who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

i) RN #100 provided the most recent annual program evaluation for the Falls Prevention Program completed for year 2017. The evaluation did not identify the summary of the changes that were made and when those changes were implemented. The RN stated that they discussed this at the meeting; however, did not document this in the annual evaluation program form. (581)

ii) RN #100 provided the most recent annual program evaluation for the Skin and Wound Program completed for year 2017. The evaluation did not identify the summary of the changes that were made and when those changes were implemented. The RN stated that they discussed this at the meeting; however, did not document this in the annual evaluation program form. (561)

RN #100 confirmed that they did not have documentation of the summary of the changes made and the date those changes were implemented for the two programs.

PLEASE NOTE: Non-compliance related to s. 30(1)4. was identified during a CI inspection log #005258-18, CIS report # 2910-000005-18 conducted concurrently with this Inspection was issued in this report as a WN (related to the Falls Management Program). [s. 30. (1) 4.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A complaint log number 007551-18, was received by the MOHLTC on an identified date in April 2018, related to the management of an altered skin integrity for resident #031. The review of progress notes for resident #031 identified that the physician had ordered specified interventions on an identified date in February 2018. The clinical record review indicated that an identified assessment was not completed on an identified date in February 2018, for the identified altered skin integrity by registered staff.

RPN #105 was interviewed on an identified date in January, 2018, and stated that the process in the home was that an altered skin integrity assessment was to be completed in Point Click Care (PCC) under the assessment tab, which was a clinically appropriate assessment designed for assessing altered skin integrity.

The home's policy titled as specified skin alteration management, policy number RC-23-01-02, revised February 2017, indicated that registered staff were to assess all residents exhibiting altered skin integrity on initial discovery. Registered staff were to use a specified Assessment Tool for an altered skin integrity and were to use another specified Assessment for all other skin impairments.

The clinical record review and interview with the DOC on an identified date in January 2018, confirmed that resident #031 had not been assessed by registered staff using a clinically appropriate skin and wound assessment tool on an identified date in February 2018.

The licensee failed to ensure that resident #031 exhibiting altered skin integrity received a specified assessment by a member of the registered staff using a clinically appropriate assessment tool. [s. 50. (2) (b) (i)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 233. Retention of resident records

Specifically failed to comply with the following:

s. 233. (2) A record kept under subsection (1) must be kept at the home for at least the first year after the resident is discharged from the home. O. Reg. 79/10, s. 233 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the record kept under subsection (1) must be kept at the home for at least the first year after the resident was discharged from the home.

A complaint log number 007551-18, was received by the MOHLTC on an identified date in April 2018 related to management of altered skin integrity for resident #031.

Resident #031 was admitted to the home on an identified date in 2015 and discharged from the home on an identified date in 2018.

Resident #031's clinical records were reviewed and identified that the resident was tested for a possible specified condition on an identified date in 2018. The specified results came back to the home with the specified test being contaminated, which required retake of the specimen. The specified sample was collected again on an identified date in 2018 as per the record review. The resident's chart was reviewed during inspection and the results of the second sample collected could not be found.

RN #100 and RN #101 both confirmed that the home did not keep a record of the specified results.

The licensee failed to ensure that the record kept at the home for at least the first year after resident #031 was discharged from the home. [s. 233. (2)]

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Issued on this 19th day of February, 2019

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

Original report signed by the inspector.