Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 20, 21, 22, 23, 24, 27, 28, 29, 30, 31, Sep 6, 7, 11, 12, 13, 2012	2012_074171_0011	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

ELISA WILSON (171), CAROL POLCZ (156), DEBORA SAVILLE (192), SHARLEE MCNALLY (141)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Executive Director, Acting Executive Director, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Registered Dietitian (RD), Registered Staff, Personal Support Workers (PSW), Dietary Aides, Maintenance Lead, Environmental Manager, Business Manager, Programs Manager, Food Service Manager, residents and family members of residents.

During the course of the inspection, the inspector(s) toured the home, observed meal service, medication passes, medication storage areas and care provided to residents, reviewed medical records and plans of care for identified residents, reviewed policies and procedures of the home, and observed the general maintenance, cleaning and condition of the home.

RQI: H-001624-12

This inspection was completed concurrently with:
2012_027192_0040 (H-000230-12, H-001606-12, H-001728-12) Complaints
2012_027192_0041 (H-000862-12, H-001390-12, H-001616-12, H-001640-12) Critical Incidents

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Reporting and Complaints

Resident Charges

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee had not ensured that every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. [LTCHA, 2007 S.O. 2007, c.8, s.3(1)4]

a) The plan of care for resident #1003 indicated specific assistance required for all aspects of care. On a specific day with the home's knowledge, the resident was being cared for by an individual who was untrained in the home's procedures, non-compliant with the plan of care and was without the assistance of staff. The resident sustained a fall that resulted in injury.

b) Resident #955 was totally dependent for all aspects of care. The resident was observed to have an injury from an unknown origin. Investigation into the cause of the injury was not initiated until one week following the identification of the injury and not all staff having contact with the resident were interviewed at that time. The investigation conducted was not successful in identifying the cause of the injury to the resident.

2. The licensee failed to ensure that every resident has the right to be protected from abuse. [LTCHA, 2007 S.O. 2007, c.8 s.3(1)2]

Resident #1004 was not protected from abuse when a staff member of the home used force when providing care. The resident sustained an injury . This event was confirmed by the Director of Care and documentation review.

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 the rights of the residents are fully respected and promoted, to be implemented voluntarily.

WN #2: 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 subsections:

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;
(b) the goals the care is intended to achieve; and
(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).

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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee had not ensured that the residents were reassessed and the plan of care reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

a) The plan of care for resident #010 was not updated after care needs changed. The care plan included contradictory information regarding the level of assistance for transferring. Staff confirmed old information was not removed from the plan of care when the resident's needs changed. (171)

b) The Resident Assessment Protocol (RAP) for physical restraints was not reviewed and revised when the resident's care needs changed. The RAP summary regarding physical restraints for resident #010 indicated the use of a specific restraint. A physician's order dated months earlier indicated the restraint was discontinued. Staff confirmed that the resident does not use a restraint and it was not included in the care plan section of the medical record. Registered staff confirmed that the expectation is that the RAP should reflect the current care needs of the resident. (171)

c) The plan of care was not reviewed and revised regarding skin tears and the location of the tears for resident #003.

i) The Treatment Administration Record (TAR) indicated that the resident had a skin tear in a specific location on the body. The weekly wound care record also indicated that the skin tear was in this location. However, another weekly wound care record indicated that the resident's skin tear had healed but indicated it was in a different location.

ii) The resident had another skin tear, however the plan of care had not been reviewed and revised to indicate clearly the location of the tear. The TAR indicated that the resident had a skin tear on one side of the body however, the weekly wound care record indicated that the resident had a skin tear on the opposite side of the body. (156)

2. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident. [LTCHA, 2007 S.O. 2007, c.8, s.6(1)(c)]

The plan of care for resident #1004 does not provide clear direction in describing individual care, the wishes of the resident's family and interventions to use if care is resisted.

Staff interviewed identified the resident tolerated some types of care but was consistently resistive to other care. On one specific day the staff member caring for the resident attempted to provide care against the wishes of the resident. Interview conducted by the home identified that the staff member persisted which caused an injury to the resident. There was no clear direction in the plan of care regarding interventions to be used when the resident resists care.(192)

3. The licensee failed to ensure that care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA, 2007 S.O. 2007, c.8, s.6(7)]

Resident #1002 had specific responsive behaviours. A plan of care including interventions for these behaviours was located on the 24 hour report binder and available to all staff.

The resident was observed by the inspector to be displaying some of these behaviours. Two staff interviewed confirmed that the plan of care indicating specific interventions to use to prevent these behaviours was not complied with prior to this observation.(192)

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 the plans of care provide clear direction, care is provided as set out in the plan of care and that plans of care are reviewed and revised when resident care needs change, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following subsections:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails are used other safety issues related to the use of the bed rails are addressed, including height and latch reliability. [O. Reg. 79/10 s. 15(1)(c)]

Resident #005 was identified to have a malfunctioning bed rail, however it was not repaired immediately. The plan of care in effect at the time indicated that the resident required two bed rails for fall prevention.

An injury was sustained due to the malfunctioning bed rail.

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 where bed rails are used other safety issues related to the use of the bed rails are addressed, including height and latch reliability, 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 subsections:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee did not ensure the plan of care for resident #961 was based on, at a minimum, interdisciplinary assessment with respect to the resident's skin condition, including altered skin integrity. [O.Reg. 79/10, s.26(3)15]

The resident had been treated four times for skin tears in a year. The resident's most current pressure ulcer Resident Assessment Protocol (RAP) identified the resident was at risk for skin breakdown and the RAP will be care planned with a goal that the resident will be free from pressure ulcers this quarter. Staff confirmed the resident is at high risk for skin breakdown and has treatment for breakdown on multiple occasions. The resident's plan of care does not include a focus statement related to skin breakdown or interventions to address the risk.

2. The licensee did not ensure the plan of care for resident #989 was based on, at a minimum, interdisciplinary assessment with respect to the resident's health conditions including risk of falls. [O.Reg. 79/10, s.26(3)10]

The resident records indicated the resident has had a number of falls in the past year. The resident's most current RAP for falls was identified as a modified RAP and stated this RAP will be care planned with a goal that the resident will remain safe with reduced falls this quarter. The plan of care does not have a focus statement related to risk of falls or identified interventions to address the risk.

3. The licensee did not ensure the plan of care for resident #989 was based on, at a minimum, interdisciplinary assessment with respect to the resident's safety risks. [O.Reg. 79/10, s.26(3)19]

The resident's current Minimum Data Set (MDS) assessment and RAP identified the resident used specific safety devices. Staff confirmed these devices were used as a restraint. There was a physician order for the devices to be used as a restraint. The care plan section of the resident's medical record did not identify these safety devices to be used as a restraint and did not identify interventions related to the restraint.

4. The licensee did not ensure the plan of care for resident #010 was based on, at a minimum, interdisciplinary assessment with respect to mood and behaviour patterns, identified responsive behaviours, potential behavioural triggers and variations in resident functioning at different times of day. [O.Reg. 79/10, s.26(3)5]

A review of the MDS and RAP information indicated this resident had specific behavioural issues. It was noted in the RAP that the care plan would include a goal that the resident would experience episodes of calm during the day.

A review of the corresponding care plan section of the resident's medical record revealed no focus statement, goals or interventions related to behaviours and mood. There was no information regarding identified responsive behaviours, potential behavioural triggers and variations in resident functioning at different times of day. Staff confirmed the resident was exhibiting these behaviours.

5. The licensee did not ensure the plan of care was based on, at a minimum, interdisciplinary assessment with respect to hydration status and risks relating to hydration. [O.Reg. 79/10, s.26(3)14]

a) Resident #007 was assessed by the Registered Dietitian as requiring a specific amount of fluid per day. The nutrition assessment in the progress notes indicated the resident was taking less than the assessed requirements, however hydration status as a focus statement, goal or specific interventions for hydration were not found in the care plan.

b) Resident #006 was assessed by the Registered Dietitian as requiring a specific amount of fluid per day. The nutrition assessment in the progress notes indicated the resident was taking less than assessed needs. There were no focus statements, goals or interventions in the plan of care to address hydration status.

Registered staff and the Food Services Manager confirmed that registered staff were expected to consult the registered dietitian if the resident took less than 1500ml/day for three consecutive days and that residents with hydration risks would be noted at report to remind staff to encourage fluid intake. There were no consults for these residents found and no documented evidence on the 24 hour report that the residents' hydration status was discussed. Two staff interviewed were unaware of any residents with a hydration risk on this home area.

c) Resident #012 returned from hospital with a diagnosis of dehydration. The dehydration RAP completed indicated dehydration would be care planned with the goal of maintaining good hydration. The care plan indicated the resident was at high nutritional risk, however hydration was not part of the focus statement, goals or interventions in the plan.

The DOC confirmed that the expectation would be that hydration issues would be a part of the nutrition section of the care plan.

6. The licensee did not ensure the plan of care for resident #003 was based on, at a minimum, interdisciplinary assessment with respect to psychological well-being. [O.Reg. 79/10, s.26(3)6]

The RAP identified that the resident had specific behaviours and this was confirmed by the registered staff. This responsive behaviour was not part of the focus statement, goals, or interventions in the care plan section of the medical record.

The RAI Coodinator confirmed the expectation was all information from the MDS assessments and RAP's that require focus statements, goals and interventions should be included in the care plan section of the medical record.

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 the plan of care is based on an interdisciplinary assessment of mood and behaviour, psychological well-being, risk of falls, hydration, skin conditions and safety risks, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following subsections:

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.
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.
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.
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).

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 did not ensure that any actions taken with respect to resident #989 under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented. [O.Reg. 79/10, s.30(2)]

The resident was scheduled for showers twice per week as per the home area's bathing schedule. The daily flow sheets documented that showering occurred 5 out of 8 scheduled times. Staff indicated the showers were being done, however the documentation of this intervention was missed.

2. The home had not ensured the Hydration program had been evaluated and updated annually in accordance with evidence-based practices. [O.Reg. 79/10, s.30(1)3]

The last date reviewed documented on the Hydration Monitoring policy (DIET-04-01-14) was January 2007 and the date last reviewed on the Fluid Intake policy (RESI-05-02-05) was December 2002 .

The DOC and Food Services Manager confirmed that these were the current policies in use at the home and that a new policy was being developed by head office.

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 assessments, reassessments, interventions and responses to interventions are documented and that the hydration program is required to be evaluated and updated annually, to be implemented voluntarily.

WN #6: 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 subsections:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;
(e) continence care products are not used as an alternative to providing assistance to a person to toilet;
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee had not ensured that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions and that the assessment was conducted using a clinically appropriate assessment instrument. [O.Reg. 79/10, s.51(2)(a)]

Resident #010 was coded as being incontinent of bowel and bladder. The MDS assessment indicated the resident's continence level changed between quarters. Care plans indicated the resident's continence needs changed over a six month period of time.

There were no documented continence assessments using a clinically appropriate assessment instrument for this resident that included causal factors, patterns, and potential to restore function with specific interventions.

Registered staff confirmed the assessment tool was not completed for this resident. The RAI Coordinator confirmed the expectation was to complete an assessment tool when the MDS coded continence level changed either up or down. This was also confirmed in the home's Continence Assessment policy "each resident will have a complete continence assessment upon admission and with any significant continence-related change in functional status or needs".

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 each resident who is incontinent receives an assessment using a clinically appropriate assessment instrument, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following subsections:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee did not comply with the condition to which the licensee is subject. Schedule C, "Terms and Conditions Applicable to the Funding" of the Long Term Care Home Service Accountability Agreement (LSAA) with the Local Health Integration Network (LHIN) under the Local Health System Integration Act, 2006, section 4.1 reads "The Health Service Provider shall use the funding allocated for an Envelope for the use set out in the Applicable Policy." [LTCHA, 2007 S.O. 2007, c.8, s.101(4)]

At the breakfast meal on August 23, 2012 in the Trafalgar home area dining room a PSW was observed to enter the servery and portion out the meal for 20 minutes. One other PSW was in the dining room and serving the meals to the residents. No residents were observed to be provided with feeding assistance during this period. Staff confirmed that this was a general practice as the dietary staff left the servery at 0900 and the meal was not generally completed until at least 0930. On the day of observation it was 0950 when the last residents were served breakfast in this home area.

Portioning out of the meal is not a direct nursing and personal care duty as defined by the Ministry of Health and Long Term Care definition of Nursing and Personal Care Envelope (NPC) and therefore not an appropriate use of staff whose wages are allocated from the NPC envelope.

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 appropriate use of staff whose wages are allocated from the NPC envelope, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee did not ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that all assessments, reassessments, and monitoring, including resident's response are documented. [O.Reg. 79/10, s.110(7)6]

a) Staff confirmed residents #1005 and 1006 had restraints applied daily. Documentation of hourly monitoring and repositioning at least every 2 hours was not consistently completed in the restraint record or progress notes when the physical restraints were applied.

b) Resident #989 was observed to have restraints applied on multiple occasions during the inspection period. Staff confirmed that the restraints are applied daily. Documentation of hourly monitoring and repositioning at least every 2 hours was not consistently completed in the restraint record or progress notes when the physical restraints were applied.

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 all assessments, reassessments and monitoring, including resident's response are documented for every use of a physical device to restrain a resident, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following subsections:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee did not ensure resident #989 received fingernail care. [O.Reg. 79/10, s.35(2)]

The resident was observed on multiple occasions during the inspection period to have fingernails that were dirty with old debris. The resident's daily flow sheets documented that nail care was completed at shower days only and staff also confirmed this is the time that nail care is completed for this resident. The home's policy and procedure "Personal Hygiene/Grooming (05-07-16) states that residents will have their fingernails cared for daily and at the bath session to ensure cleanliness of fingernails and hands.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs
Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and
(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.

Findings/Faits saillants :

1. The licensee did not ensure that any medical directive or order for the administration of a drug to a resident was used unless it was individualized to the resident's condition and needs. [O.Reg. 79/10, s.117(b)]

Medication orders for multiple residents with direction to administer the medication as required (PRN) did not consistently provide clear direction for the need of the medication.

The pharmacy quality audit of May 24, 2012 indicated that reason for use of PRN medication was not always indicated. The home's policy and procedure "PRN Medication"(11-22) indicated each PRN order must state under what conditions the product was to be used. The DOC confirmed the physicians were not consistently including the conditions for administering the PRN medication.

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 any medical director or order for the administration of a drug to a resident is individualized to the resident's condition and needs, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 225. Posting of information
Specifically failed to comply with the following subsections:

s. 225. (1) For the purposes of clause 79 (3) (q) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 79 of the Act includes the following:
1. The fundamental principle set out in section 1 of the Act.
2. The home's licence or approval, including any conditions or amendments, other than conditions that are imposed under the regulations or the conditions under subsection 101 (3) of the Act.
3. The most recent audited report provided for in clause 243 (1) (a).
4. The Ministry's toll-free telephone number for making complaints about homes and its hours of service.
5. Together with the explanation required under clause 79 (3) (d) of the Act, the name and contact information of the Director to whom a mandatory report shall be made under section 24 of the Act. O. Reg. 79/10, s. 225 (1).

Findings/Faits saillants :

1. The licensee had not ensured that all information required to be posted and communicated to residents was posted. [O.Reg. 79/10, s.225(1)3]

The most recent audited report was not found during a review of the posted material completed on August 29, 2012.

It was confirmed by the business manager that this document was not posted.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following subsections:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights;
(b) the long-term care home's mission statement;
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
(d) an explanation of the duty under section 24 to make mandatory reports;
(e) the long-term care home's procedure for initiating complaints to the licensee;
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints;
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained;
(h) the name and telephone number of the licensee;
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home;
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home;
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges;
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge;
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs;
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents;
(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package;
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations;
(q) an explanation of the protections afforded by section 26; and
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

Findings/Faits saillants :

1. The licensee had not ensured that the admission package included all of the sections as required in this Act. [LTCHA 2007, S.O. 2007, c.8, s.78(2)g,q]

The admission package was reviewed on August 29, 2012:

The admission package did not include an explanation of whistle-blowing protections related to retaliation.

2. The admission package did not include the home's policy on minimizing the restraining of residents and how to obtain a copy of the policy.

The business manager confirmed these two pieces of information were missing from the admission packages.

WN #13: 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 subsections:

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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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 had not ensured that the home was maintained in a safe condition and in a good state of repair. [LTCHA, 2007 S.O. 2007, c.8, s.15(2)(c)]

During a tour of the home with maintenance staff on August 23, 2012 it was noted that there was a hole in the floor near the drain in the Bronte home area spa. Maintenance indicated the floor was scheduled to be replaced this year. This was confirmed by the Acting Executive Director.

It was also noted that the door frame guard on the clean utility room door in the Bronte home area was cracked and broken from the carts that were stored in the room. The chipped plastic on the door frame could potentially catch on clothing or skin. The clean utility room in the Oakville home area was similarly cracked and broken, although to a lesser degree. The poor state of repair of the door guards was confirmed by Maintenance and the DOC.

2. The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary. [LTCHA, 2007, S.O. 2007, c.8 s. 15(2)(a)]

On August 23, 2012 during observation of the noon medication pass on the Bronte home area, it was observed that the exterior of the medication cart was heavily soiled with spilled products on the right side by the garbage can. The exterior of the garbage can, base of the cart and pull out on the right side of the cart were also observed to be soiled. The container on the left side of the cart, holding the clean glasses was also noted to contain loose debris.

The nurse interviewed indicated it was the nurses responsibility to clean the interior and exterior of the medication cart and confirmed that the cart was heavily soiled, especially on the right side.

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:

CORRECTED 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.	CO #001	2012_072120_0010	192

Issued on this 21st day of September, 2012

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

Elisa Wilson