Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 16, 2015	2015_195166_0004	O-001749-15	Resident Quality Inspection

Licensee/Titulaire de permis

REGENCY LTC OPERATING LP ON BEHALF OF REGENCY
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

THE WYNFIELD
451 Woodmount Drive OSHAWA ON L1G 8E3

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

CAROLINE TOMPKINS (166), KELLY BURNS (554), MARIA FRANCIS-ALLEN (552), SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 4, 5, 6 and March 9,10, 11, 2014

During the course of this inspection, complaint log O-001706-15 and critical incident log O-000624-14 were inspected concurrently

During the course of the inspection, the inspector(s) spoke with Residents, Family, the Resident Council President, Administrator, Director of Care(DOC), Assistant Directors of Care(ADOC), Environmental Service Manager(ESM), Housekeepers, Maintenance Manager, Director of Social Service, Personal Care Providers(PCP), Registered Practical Nurses(RPN), Registered Nurses(RN), Physiotherapy Assistant, Program Manager and Recreation Aides.
The Inspectors also observed staff to resident interactions during the provision of care, observed 2 meal services, toured resident rooms and common areas, observed medication administration and infection control practices.
Clinical health records, licensee's investigation documentation and the licensee's policies related to infection control, resident care plans ,heat prevention-hot weather and resident abuse prevention program were reviewed.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 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. (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. Log O-000624-14
The licensee has failed to ensure that care set out in the plan of care for Resident #16, was provided as specified in the plan.
As per critical incident report(CIR)an after hours call was received reporting that Resident #16 had sustained an irritation of the skin.
Review of CIR, clinical documentation, the licensee's investigation and interviews with the Director of Care, RPN and PCP #118, indicated that PCP #118 was aware of the licensee's intervention relating to care of residents when outside.
On the specified day of the incident, PCP #118 did not follow the precautions as had been instructed by RPN #101 and as directed in the licensee's interventions relating to care of residents when outside. [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 care set out in the plan relating to hot weather interventions is provided to all residents as specified when outside., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 5, by ensuring that the home is a safe and secure environment for its residents.

The following observation was made on March 04, 2015:
- During the initial tour of the home, an inspector was able to open the garbage chute room door (Room #177A). The garbage chute room is located on the main floor in the Garden Courtyard, which is a resident accessible area.

Staff #105 and #107 indicated that staff from both MacLaughlin Bay and Lynde Creek use Room #177A on a daily basis to dispose of garbage waste during their scheduled shifts.

The Administrator indicated to an inspector that the garbage chute room was to be locked at all times.

As of mid-day March 04, 2015, the Maintenance Manager was installing a lockable door handle to the door of Room #177A.

A further observation of Room #177A was conducted on March 5, 2015, at approximately 11:14 hours, where the inspector once again found the garbage chute room to be unlocked. (Note: attached to this door was signage advising all staff: this door must remain locked at all times. After notification of the unlocked door on March 5, 2015, the Maintenance Manager replaced a defective door handle.
Observation of room #177A from March 5, 2015(post repair of door handle) until completion of this inspection, the door has remained locked. [s. 5.]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 15 (2) (c), by ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following observations were made during the dates of March 04 through to March 06, 2015 and March 10, 2015:

- Walls – scuffed, scraped/gouged, paint chipping or areas visible damage (holes in wall, or steel corners exposed) – room(s) located on, Samac Trail; Purple Woods; Collins Path; MacLaughlin Bay; Lynde Creek and in Spa Room(s) #169, 199, 267b, 266, and #392

- Toilets – brownish staining visible at base of toilet and flooring – resident room(s) located on Samac Trail; Lynde Creek; MacLaughlin Bay; MacLaughlin Bay shower room and common restroom #386

- Flooring – cracked, split or torn with exposed subflooring exposed – resident room(s) located on Samac Tail; Purple Woods and in Spa Room #380 (Note: uneven surfaces pose a potential trip/falls hazard)

- Flooring – brownish staining visible on laminate flooring (flooring edges along wall behind tub and under baseboard heater) in Spa Room #392

- Vanity Counters – laminate missing on washroom vanities – resident room(s) located on Samac Trail; Purple Woods; Collins Path; Lynde Creek; and MacLaughlin Bay (Note: surfaces where laminate missing is porous in nature and poses a potential infection

control concern)

- Wall Guard – cracked – in a resident room located on Samac Trail; area is approximately 2cm W x 5cm L, the exposed area is jagged and sharp)

- Tub – MacLaughlin Bay Spa Room (#169) – acrylic finishing on tub (inside) surface is chipped in two areas (Note: this is a porous surface which poses a potential infection control issue)

The home's Maintenance Log binders were reviewed on all Resident Home Areas for the period of January 01, through to March 09, 2015 the above areas requiring repair were not identified.

The Environmental Services Manager and Maintenance Manager indicated awareness of some of the above areas requiring repair or replacement and indicated the following:
- the home does have a painting program in place and has contracted services who come in and routinely paint resident rooms and home areas; ESM indicated that the majority of resident rooms on the main floor have been painted as of November last year; the plan for this year is to complete painting in all resident common areas and gradually complete resident rooms over the same time period
- flooring in the Spa (tub/shower) rooms have been identified as needing repairs and it has been noted to have these areas repaired this year
- the home has tried to remove staining around resident toilets but have not been successful in finding a chemical to remove the stains as of this time. [s. 15. (2) (c)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 107 (3) 4., by ensuring the Director is informed no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

Related to Resident #3:
Review of critical incident report(CIR), clinical documentation and interview with the Director of Care(DOC) indicated:
- Resident #3 fell to the floor and was transferred to the hospital for further assessment and admitted for further treatment.
Review of clinical documentation, indicated that the home was notified of the resident's condition and notes further indicate that the Registered Nurse, in charge of the unit where the resident resides was made aware of resident's condition.

The Director was not notified of the injury and the transfer/ admission to the hospital until 2 days after the injury had occurred. [s. 107. (3) 4.]

2. The licensee failed to comply with O. Reg. 79/10, s. 107 (3) 4., by ensuring the Director is informed no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

Related to Resident #1:
Review of critical incident report(CIR), clinical documentation and interview with the Director of Care(DOC) indicated:
- on a specified date, Resident #1 reported losing balance when ambulating and falling. Resident #1 complained of pain. The resident was assessed, transferred to bed and provided an analgesic. At the time of the fall, resident reports using his/her walker and was wearing shoes.

Review of clinical documentation indicated:
-on the day of the incident, post fall, Resident #1 complaining of pain and unable to move in bed.
-on the day following the incident, Resident #1 was transferred to hospital for further assessment. No injuries were noted. Resident continued to complain of pain, despite use of analgesic.The resident's care plan was revised to indicate the resident had a

significant change in their physical ability to be independent.
-on the second day following the incident, Resident #1 was again transferred to hospital for further assessment. Results of assessment indicated the resident did sustain an injury.
A review of the written plan of care prior to the fall incident indicated Resident #1 was independent with their activities of daily living, including personal care.
Review of clinical records indicate that Resident #1, post fracture, now requires two staff to provide extensive assistance with all activities of daily living
Associate Director of Care (ADOC)#115 indicated that the Director was not notified of Resident #1's significant change in condition post fall nor the resulting injury. [s. 107. (3) 4.]

Issued on this 16th day of March, 2015

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

Original report signed by the inspector.