Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 7, 2013	2012_128138_0043	O-001956-12	Complaint

Licensee/Titulaire de permis

DUNDAS MANOR LIMITED
533 CLARENCE STREET, P.O. BOX 970, WINCHESTER, ON, K0C-2K0

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

DUNDAS MANOR NURSING HOME
533 CLARENCE STREET, P.O. BOX 970, WINCHESTER, ON, K0C-2K0

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

PAULA MACDONALD (138)

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): December 4, 2012

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Nurse Manager, Recreation Manager, PSW Manager, a registered practical nurse (RPN), and personal care workers.

During the course of the inspection, the inspector(s) reviewed a resident health care record, reviewed Critical Incident Report submitted to MOHLTC, reviewed a policy on resident transfers, and observed a resident's chair.

The following Inspection Protocols were used during this inspection:

Personal Support Services

Findings of Non-Compliance were found during this inspection.

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).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) (c) in that the licensee failed to ensure that there was a written plan of care for a resident that sets out clear direction to staff who provided direct care to the resident.

A resident was know to have fragile skin prior to a skin tear incident in August 2012 as confirmed by the Director of Care, Recreation Manager, Nursing Manager, and two members of the nursing staff. A review of the health care record further supported that the resident had fragile skin as the progress note entries outlined a variety of skins tears.

Despite the consensus that the resident had fragile skin prior to the incident in August 2012, the resident's plan of care dated June 2012 did not address the resident's fragile skin relating to potential skin tears and did not provide the staff with clear direction in caring for the resident's fragile skin with respect to skin tears. The Nursing Manager confirmed that the plan of care was used by the home to direct staff in the resident's care. [s. 6. (1) (c)]

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 provides clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10, s. 107. (4) 2. ii. in that the licensee failed to provide the names of staff members present when making a report in writing to the Director with respect to an incident.

The Critical Incident (CI) Report submitted by the home outlined a description of an incident in which a resident suffered a skin tear. This was noticed by staff after the resident was transferred to his/her chair.

The CI further listed the names of the staff members present when the incident occurred however it was confirmed by the staff member who responded to the incident that the information in the CI regarding staff members present was incorrect. The responding staff member and the two staff members present were able to confirm those present when the incident occurred. [s. 107. (4) 2. ii.]

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

Issued on this 7th day of January, 2013

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

Paula MacDonald RD