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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
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119, rue King Ouest, 11iém étage
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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
Mar 10, 2014	2014_247508_0005	H-000195-14	Complaint

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

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

THE VILLAGE OF WENTWORTH HEIGHTS
1620 UPPER WENTWORTH STREET, HAMILTON, ON, L9B-2W3

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

ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 20, February 21, 2014

This complaint inspection was conducted concurrently with CI inspection #2014_247508_0006

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care(DOC), registered staff, Personal Support Workers(PSW'S), Resident Assessment Instrument(RAI)Co-ordinator and residents

During the course of the inspection, the inspector(s) reviewed policies and procedures related to falls prevention, pain, skin and wound, reviewed resident health records and observed residents

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Skin and Wound Care

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

Findings/Faits saillants :

1. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Previously issued 2011/05/17 - VPC

During an observation of resident #001 on an unidentified date in 2014, it was observed that while the resident was sleeping in bed, the call bell was lying on the floor behind the resident's foot board. The clip to attach the cord to the resident's bed was broken off. Staff indicated that they do not provide the resident with access to the call bell. A review of the resident's plan of care indicates that the call bell is to be within reach.
It was confirmed by the Director of Resident Care and the Administrator that the call bell should have been within the resident's reach.

It was also observed that while resident #001 was in bed, that the floor mat was folded and propped up on the other side of the room. It was confirmed by staff that the resident's floor mat should be placed at the side of the resident's bed while the resident is in bed. A review of the resident's plan of care indicates that the floor mat is to be used at the bedside at all times. [s. 6. (7)]

2. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed. 6. (10) (b)

Previously issued 2012/12/6 – WN, VPC

(A)Resident #001 had an unwitnessed fall on an unidentified date in 2014. The resident complained of pain during the initial post fall assessment. A review of the clinical records indicated that resident #001 complained of pain four times after the fall. There were no further documented assessments post fall. An X-ray confirmed that the resident had sustained a fracture and the resident was transferred to hospital. The resident was not reassessed and the plan of care was not reviewed or revised to address the resident's pain.

(B)Resident #002 was admitted to the home on an unidentified date in 2014. The admission notes indicate that resident #002 had a history of multiple falls prior to admission. The resident had a fall and verbalized pain. A review of the clinical records indicates that the resident complained of pain six times before it was confirmed by an x-ray that the resident sustained a fracture.
Resident #002 had a second fall which resulted in an injury and a transfer to the hospital. The resident was treated in hospital and returned back to the home.
The resident was not reassessed and the plan of care did not identify the resident's risk for falls or pain as a focus until after resident #002 sustained injuries from a third fall. It was confirmed by x-ray that the resident had a fracture.

The RAI Co-ordinator confirmed that the resident was not reassessed and the plan of care updated to address resident #002's pain or high risk for falls until after the resident had three falls that resulted in injuries and a transfer to hospital. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 care set out in the plan of care is provided to the resident as specified in the plan, 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 did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Previously issued 2012/12/6 - WN

Resident #001 had an unwitnessed fall on an unidentified date in 2014, resulting in a fracture which was confirmed by x-ray on a later date. According to the home's Falls Prevention and Management policy in the Nursing manual, staff are required to assess residents each shift for 24 hours after a fall and complete a progress note for all three shifts. A review of the clinical records indicate that an initial post fall assessment had been completed. There was no follow up assessment documented on the following day shift or on the evening shift.
It was confirmed by the Director of Care that the staff did not comply with the home's Falls Prevention and Management policy. [s. 8. (1) (a),s. 8. (1) (b)]

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

Issued on this 10th day of March, 2014

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

ROSEANNE WESTERN

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ROSEANNE WESTERN (508)
Inspection No. / No de l'inspection :	2014_247508_0005
Log No. / Registre no:	H-000195-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 10, 2014
Licensee / Titulaire de permis :	OAKWOOD RETIREMENT COMMUNITIES INC. 325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	THE VILLAGE OF WENTWORTH HEIGHTS 1620 UPPER WENTWORTH STREET, HAMILTON, ON, L9B-2W3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	VANDA KOUKOUNAKIS

To OAKWOOD RETIREMENT COMMUNITIES INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that all residents including resident #001 and #002 are reassessed and their plan of care reviewed and revised when the resident's care needs change.

Grounds / Motifs :

1. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed. 6. (10) (b)

Previously issued 2012/12/6 – WN, VPC

(A)Resident #001 had an unwitnessed fall on an unidentified date in 2014. The resident complained of pain during the initial post fall assessment. A review of the clinical records indicated that resident #001 complained of pain four times after the fall. There were no further documented assessments post fall. An X-ray confirmed that the resident had sustained a fracture and the resident was transferred to hospital. The resident was not reassessed and the plan of care was not reviewed or revised to address the resident's pain.

(B)Resident #002 was admitted to the home on an unidentified date in 2014. The admission notes indicate that resident #002 had a history of multiple falls prior to admission. The resident had a fall and verbalized pain. A review of the clinical records indicates that the resident complained of pain six times before it was confirmed by an x-ray that the resident sustained a fracture.
Resident #002 had a second fall which resulted in an injury and a transfer to the hospital. The resident was treated in hospital and returned back to the home. The resident was not reassessed and the plan of care did not identify the resident's risk for falls or pain as a focus until after resident #002 sustained injuries from a third fall. It was confirmed by x-ray that the resident had a fracture.

The RAI Co-ordinator confirmed that the resident was not reassessed and the plan of care updated to address resident #002's pain or high risk for falls until after the resident had three falls that resulted in injuries and a transfer to hospital. [s. 6. (10) (b)] (508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 28, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
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En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 10th day of March, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Roseanne Western

Service Area Office /
Bureau régional de services : Hamilton Service Area Office