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
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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 30, Sep 4, 6, 7, 27, 2012	2012_039126_0006	Complaint Log # O-001900-12

Licensee/Titulaire de permis

DEEM MANAGEMENT LIMITED
2 QUEEN STREET EAST, SUITE 1500, TORONTO, ON, M5C-3G5

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

WELLINGTON HOUSE NURSING HOME
990 EDWARD STREET NORTH, P.O. BOX 1510, PRESCOTT, ON, K0E-1T0

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

LINDA HARKINS (126)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, office Manager, several registered nursing staff and several personal support workers

During the course of the inspection, the inspector(s) reviewed the resident health care record

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Medication

Nutrition and Hydration

Prevention of Abuse, Neglect and Retaliation

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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding.

2. An unexpected or sudden death, including a death resulting from an accident or suicide.

3. A resident who is missing for three hours or more.

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s.107. (1) in that the Director was not informed immediately, in as much as possible detail as is possible in the circumstances, of an unexpected or sudden death in the home.

Resident # 8 was readmitted to the Home in mid July 2012. The resident was seen by the Physician who documented in the Doctor's orders and progress notes, "Will continue with the same therapeutic measures".
At the beginning of an identified night shift in August 2012, during nursing rounds, resident # 8 was found in bed and had a large projectile emesis of undigested food. A telephone call was placed to the on call physician and an order was received to send the resident to hospital for an assessment. 911 call placed at 01:15. The Registered night Nurse prepared the documents needed for the hospital transfer. When the RN went to the resident room she/he found that resident #8 had ceased to breathe.

Discussion held with several nursing staff (registered nurses, registered practical nurses and personal support workers) regarding resident #8 and they stated that resident was his/her usual self on day and evening prior to his/her passing.

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 Director is informed immediately, in as much as possible details as is possible in the circumstances, of an unexpected or sudden death in the home., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following subsections:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10s. 131. (2) in that drugs administered to resident #8 was not in accordance with the directions for the use specified by the prescriber.

Resident #8 physician order was to administer an anti diarrheal medication twice a day and hold if no bowel movement for 2 days.

Resident #8 was administered the anti diarrheal medication when it should have been on hold because the resident did not have a bowel movement for 2 days.

On a specific date in August 2012, it is noted by the registered nursing staff that resident #8 did not have a bowel movement for 4 days. The anti diarrheal medication was administered to the resident on two occasions.

It is noted on the Extendicare daily care flow sheet that on identified dates in August 2012, that resident #8 did not have a bowel movement and the medication should have been on hold. The anti diarrheal medication was administered to resident #8, several times in August 2012 even if he/she did not have a bowel movement for two days.

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 drugs administered to residents is in accordance with the directions for the use specified by the prescriber., to be implemented voluntarily.

Issued on this 27th day of September, 2012

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

L Harkness