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

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347 Preston St, 4th Floor
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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
Aug 14, 2013	2013_184124_0014	O-339-13, O -671-13	Complaint

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

LYNDA HAMILTON (124)

Inspection Summary/Résumé de l'inspection

Ontario

Ministry of Health and Long-Term Care

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

This inspection was conducted on the following date(s): July 18, 19, 22, 23, 24, 25, 26, 2013.

Two complaint logs, O-000339-13 and O-000671-13 were inspected during this inspection. The report contains a finding from Critical Incident Inspection #2013_184124_0013 for log O-000591-13.

During the course of the inspection, the inspector(s) spoke with Residents, family members, the Administrator, Director of Care, Registered Nurse, Registered Practical Nurses, Personal Support Workers and Physiotherapy Assistant.

During the course of the inspection, the inspector(s) completed walking tours of the home, observed resident-staff interactions, made general observations regarding resident care, reviewed resident health records and the home's policies related to safe transfers and risk management reporting.

The following Inspection Protocols were used during this inspection:
Personal Support Services

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. The licensee failed to comply with the LTCHA 2007, s.6 (7) whereby resident #2 and #7 did not receive care as specified in their plans of care.

This finding refers to log O-000671-13

Resident #2 mobilizes by wheelchair, has a tabletop for the wheelchair and is transferred by mechanical lift.

On a specified date, Resident #2 had slid down in the wheelchair as reported in Critical Incident # 2807-000032-13.

Staff #104 and Staff #109 reported to the inspector that Resident #2 had been sitting on the transfer sling at the time the resident slid down in the chair.

Staff #104 described the mesh of the sling as slippery.

Staff #107, the home's wound care nurse stated that Resident #2 should not sit on the sling because it is plastic and can contribute to skin breakdown. Resident #2 has a skin breakdown.

On another date, inspector 124 observed Resident #2 sitting on the transfer sling.

The home's Mechanical Lift Policy and Procedure #05-08-04, Procedure point 25, states "Remove sling from underneath client unless indicated on the Care Plan". The Administrator and the Director of Care confirmed that the home's policies and procedures are considered to be part of each resident's plan of care. Resident #2's plan of care in place at the time of the incident did not direct staff to leave the transfer sling under the resident.

Resident #2 did not receive care as specified in the plan of care, on two specified dates; the transfer sling was not removed as per the home's direction. [s. 6. (7)]

2.This finding relates to log O-000591-13

Resident #7 has diagnoses of dementia, arthritis and is incontinent of urine.

Staff #115 reported to the inspector that during morning care on a specified date

he/she had left Resident #7 standing at the toilet while he/she went to retrieve the resident's dentures. Staff #115 stated that he/she knew other staff had left the resident sitting on the toilet and stated he/she did not see the difference between the resident standing and sitting. Staff #115 said he/she heard the resident fall and found the resident on the floor.

It is documented in the home's description of the incident that after lunch on the specified date, resident #7 began to complain of pain in the right arm and was sent to hospital for assessment.

Resident #7's plan of care in place at the time of Resident #7's fall identified that the resident was at risk of falls and directed staff to transfer the resident onto the toilet/commode.

Resident #7 did not receive care as specified in the plan of care and subsequently sustained a fall that required the resident to go to hospital. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 14th day of August, 2013

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

L Hamilton RegN

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

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) :	LYNDA HAMILTON (124)
Inspection No. / No de l'inspection :	2013_184124_0014
Log No. / Registre no:	O-339-13, O-671-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 14, 2013
Licensee / Titulaire de permis :	DEEM MANAGEMENT LIMITED 2 QUEEN STREET EAST, SUITE 1500, TORONTO, ON, M5C-3G5
LTC Home / Foyer de SLD :	WELLINGTON HOUSE NURSING HOME 990 EDWARD STREET NORTH, P.O. BOX 1510, PRESCOTT, ON, K0E-1T0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	

To DEEM MANAGEMENT LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

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. (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).

Order / Ordre :

The licensee shall ensure that residents are not left sitting on transfer slings unless this is specified in the resident's plan of care and that residents are toileted in accordance with their plans of care.

Grounds / Motifs :

1. This non-compliance was issued on May 9, 2013 as part of inspection 2013_184124_0008 as a Written Notification and a Voluntary Plan of Correction. It remains non-compliant as evidenced by the following findings.

The licensee failed to comply with the LTCHA 2007, s.6 (7) whereby resident #2 and #7 did not receive care as specified in their plans of care.

This finding refers to log O-000671-13

Resident #2 mobilizes by wheelchair, has a tabletop for the wheelchair and is transferred by mechanical lift.

On a specified date, Resident #2 had slid down in the wheelchair as reported in Critical Incident # 2807-000032-13.

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Staff #104 described the mesh of the sling as slippery.

Staff #107, the home's wound care nurse stated that Resident #2 should not sit

on the sling because it is plastic and can contribute to skin breakdown. Resident #2 has a skin breakdown.

On another date, inspector 124 observed Resident #2 sitting on the transfer sling.

The home's Mechanical Lift Policy and Procedure #05-08-04, Procedure point 25, states "Remove sling from underneath client unless indicated on the Care Plan". The Administrator and the Director of Care confirmed that the home's policies and procedures are considered to be part of each resident's plan of care. Resident #2's plan of care in place at the time of the incident did not direct staff to leave the transfer sling under the resident.

Resident #2 did not receive care as specified in the plan of care, on two specified dates; the transfer sling was not removed as per the home's direction. [s. 6. (7)]
(124)

2. Resident #7 has diagnoses of dementia, arthritis and is incontinent of urine.

Staff #115 reported to the inspector that during morning care on a specified date he/she had left Resident #7 standing at the toilet while he/she went to retrieve the resident's dentures. Staff #115 stated that he/she knew other staff had left the resident sitting on the toilet and stated he/she did not see the difference between the resident standing and sitting. Staff #115 said he/she heard the resident fall and found the resident on the floor.

It is documented in the home's description of the incident that after lunch on the specified date, resident #7 began to complain of pain in the right arm and was sent to hospital for assessment.

Resident #7's plan of care in place at the time of Resident #7's fall identified that the resident was at risk of falls and directed staff to transfer the resident onto the toilet/commode.

Resident #7 did not receive care as specified in the plan of care and subsequently sustained a fall that required the resident to go to hospital. [s. 6. (7)] (124)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 23, 2013

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

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

and the Director

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

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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

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 14th day of August, 2013

Signature of Inspector / Signature de l'inspecteur : L Hamilton

Name of Inspector / Nom de l'inspecteur : LYNDA HAMILTON

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