Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Jun 26, 2015	2015_250511_0008	H-002359-15	Resident Quality Inspection

Licensee/Titulaire de permis

BARTON RETIREMENT INC.
1430 UPPER WELLINGTON STREET HAMILTON ON L9A 5H3

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

THE WELLINGTON NURSING HOME
1430 UPPER WELLINGTON STREET HAMILTON ON L9A 5H3

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

ROBIN MACKIE (511), CAROL POLCZ (156), IRENE SCHMIDT (510a)

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): May 4-8th, 11th-15th, 19 and 20th, 2015

**The following inspections were completed during the course of the RQI:
1. Log # 003565-14/CIS # 1023-000016-14, 2. Log # 001601-15/CIS #2784-000004-15,
3. Log #001956-15/CIS #2784-000005-15,
4. Log # 004158-15/CIS 2784-000011-15, 5. Log # 004160-15/CIS #2784-000012-15, 6. Log # 004718-15/CIS 2784-000014-15, 7. Log # 004794-15/COMPLAINT IL37847, 8 Log # 007200-15/Complaint IL 38251**

During the course of the inspection, the inspector(s) spoke with family members, residents, Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Unit Clerk, Maintenance Manager, Food Service Supervisor, Resident Support Service Worker, Nurse Manager, Registered staff; inclusive of Registered Nurses (RN) and Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist (PT), housekeeping staff and dietary aides.

During the course of the inspection, the inspector(s) observed the provision of resident care, toured the home, reviewed relevant policies, procedures and resident clinical records, including Resident Assessment Instrument-Minimum Data Set (RAI-MDS) and Resident Assessment Protocols (RAP).

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
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
Trust Accounts

During the course of this inspection, Non-Compliances were issued.

16 WN(s)
2 VPC(s)
2 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 O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, (a) the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

A) Resident #002 was noted to be sleeping in their bed on a specific day in 2015 with two-half bed rails in place. A review of the resident's clinical record did not indicate the resident was assessed, in their bed in accordance with evidenced-based practice, when bed rails were used in order to minimize risk to the resident. (511)

B) The bed of resident #024 was observed to have one-half rail and one-assist rail in the up position, both when the resident was in bed and when the resident was not in bed. A review of the clinical record revealed the absence of a resident assessment for bed rails. (156)

C) The bed of resident #039 was observed to have bed rails in the up position. The plan of care for resident #039 indicated that two-three quarter rails were to be raised when the resident was in bed. A review of the resident's clinical record did not indicate the resident was assessed, in their bed in accordance with evidenced-based practice, when bed rails were used in order to minimize risk to the resident. (510)

Interview with the DOC confirmed the licensee failed to ensure that where bed rails were used for resident #002, #024 and #039 that they were assessed, in accordance with evidence-based practices and if there were none, in accordance with prevailing practices to minimize risk to the residents taking into consideration all potential zones of entrapment. [s. 15. (1) (a)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations

Every licensee of a long-term care home shall ensure that,

(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and

(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident’s behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Resident #208 had a Cognitive Performance Scale (CPS) of 3 and was identified as having a history of physical and verbal aggression related to dementia and anxiety. The Resident Assessment Protocol (RAP) dated January 2015 indicated the resident presented with responsive behavioural and adverse mood behaviours on a daily basis. The RAP further indicated the need for interventions to reduce physical and verbal aggression. Review of the progress notes revealed that in the morning, on a specified day in 2015, resident #208 had a number of altercation with two separate residents. Staff intervened in both of these incidents. During the same morning resident #208 was left unattended and unsupervised, when there was an unwitnessed altercation between resident #208 and resident #207, in the hallway in front of their room and the nursing station. When staff responded to the commotion, they found both residents had sustained injuries from the altercation and they required transfer to the hospital. Resident #208 had a fracture and returned to the home. Resident #207 was admitted to hospital with a fracture and other injuries.
Interview with the DOC and registered staff confirmed that the resident had been assessed and it was understood by the home what the primary trigger was for the altercation. The DOC confirmed the resident had demonstrated two episodes of responsive behaviors based on this primary trigger, on the morning in question and that the resident should not have been left unattended in the hallway.
Procedures and interventions were not implemented to assist residents who were at risk of harm as a result of a resident's behaviours, including responsive behaviours, and that would minimize the risk of altercations and potentially harmful interactions between and among residents.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #3: 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).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 failed to ensure that there was a written plan of care for each resident that set out, (c) clear directions to staff and others who provided direct care to the resident.

A review of the clinical record for resident #302 indicated the resident had a fall in 2015 that resulted in a transfer to hospital with an injury. The resident's most recent plan of care indicated the resident was weight bearing with assistance and had a trial of using hip protectors that was unsuccessful, resulting in them not being used. In the same plan of care their was direction for hip protectors to be worn by the resident and an intervention that the resident was not weight bearing. Interview with the DOC confirmed the written plan of care did not provide clear direction to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A) Three front line staff, as well as the DOC and Nursing Rehabilitation Coordinator, reported on a day in 2015 that resident #039 was a two person transfer and required two bed rails to keep the resident in bed. The plan of care for this resident indicated that two, three quarter, bed rails were to be raised when the resident was in bed.
The latest quarterly MDS assessment in 2015, indicated under section G. question 1. a) that resident #039 was totally dependent for bed mobility and required two persons to assist; however, question 6 of the assessment indicated that the resident required bed rails to be used for bed mobility or transfer which was incorrect. Staff involved in the different aspects of care failed to collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other as confirmed with the Nursing Rehabilitation Coordinator and DOC on May 11, 2015. (156)

B) A review of the clinical record for resident #301 indicated the resident was admitted to the home in 2015. Their Contact Assessment Report, provided from the Community Care Access Centre (CCAC), dated the month before their admission, indicated the resident had been recently admitted to the hospital due to a fall within their own home. The assessment confirmed the resident also had a fall while in the hospital, was unsteady and remained at a high risk for falls on admission to the Long Term Care home. The Assessment Criteria and Care plan for Safe Patient Handling , completed by the home's PT indicated a history of falls, severe pain and discomfort. The PT assessment, documented in the progress notes just after admission in 2015, identified the resident to be at a moderate risk for falls based on their balance and gait score and had placed them in the physiotherapy program to reduce the risk for falls and injury. The MDS Falls risk assessment, completed by the registered staff, on the same date had indicated the resident was not at a risk for falls and coded the resident as having no falls in the previous 90 or the previous 31-180 days.
Interview with the DOC confirmed the registered staff and PT had not collaborated with each other in their assessments of the resident so that their assessments were integrated and were consistent with and complemented each other.(511) [s. 6. (4) (a)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (c) care set

out in the plan had not been effective.

Resident #208 was identified as having a history of physical and verbal aggression related to dementia and anxiety. They were assessed by Behavior Supports Ontario (BSO) and discharged in 2014. The Care Plan dated in January 2015 included a focus for Violence/Aggression Risk Assessment, and identified the resident as high risk and directed staff to the responsive behavior care plan. The responsive behavior focus further directed staff to the behavior support plan, which set out detailed triggers and care approaches for the resident. In February and March 2015 there were a number of incidents of physical aggression with co-residents documented in the progress notes. There was no evidence in the clinical record that the care plan for responsive behaviors was reviewed and revised in response to these incidents. The DOC confirmed that the care plan was not reviewed or revised when the care set out in the plan was not effective. [s. 6. (10) (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 that resident #208 is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (c) care set out in the plan has not been effective, to be implemented voluntarily.

WN #4: 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 failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, instituted or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with.

A) A review of the home's "Falls Prevention and Management Program", NUR-V-166, revised April 2015, required the licensee to ensure the Falls Nurse Coordinator identified residents as “High Risk” when he/she fell two times in any three month period. Once the resident was identified, the Falls Nurse Coordinator would conduct a Falls Team meeting to complete a Multifactorial Assessment on that resident. Members of the Falls Prevention and Management Team would then meet quarterly (Falling Star Committee) and review all high risk residents and use the above criteria and clinical nursing judgment to determine if those residents were still at high risk for falls.

A review of the clinical record for resident #302 indicated they were admitted on a specific month in 2014 and had experienced a number of falls in the same month. The resident experienced more falls the the months to follow. The resident was identified, as per the plan of care, as a high risk for falls during the admitting month in 2014. A review of the Falling Star Committee meeting minutes for the month following the resident's admission did not identify the resident as a high risk for falls, nor had they reviewed resident #302's falls during the month of their admission in 2014 as per the "Falls Prevention and Management Program", NUR-V-166 policy.
Interview with the DOC confirmed the home's Falls Prevention Management Program was not complied with when resident #302's falls were not reviewed at the Falling Star Committee meeting as required by policy NUR-V-166.

A review of the clinical record for resident #301 indicated they were admitted in 2015 and had experienced a fall during this month and another fall the following month. The resident experienced the third fall during this second month of admission which resulted in a transfer to the hospital and a diagnosis of a fracture. The resident was not identified in the home`s Falling Star program until after the fracture. A review of the Falling Star Committee meeting minutes, after the resident was identified in the Falling Star program, still had not identified the resident as a high risk for falls, nor had the home reviewed resident #301's three falls as directed by the "Falls Prevention and Management Program", NUR-V-166 policy.
Interview with the DOC confirmed the homes' Falls Prevention Management Program

was not complied with when resident #301's falls were not reviewed at the Falling Star Committee meeting as required by policy NUR-V-166.

B) The Falls Prevention and Management Program", NUR-V-166 identified, as part of the monitoring and evaluation of resident outcomes, the Physiotherapist (PT) would be required to evaluated and reassessed the resident's status post fall.

A review of the clinical record indicated the PT assessed the resident #302 post admission on a specified date in 2014 and indicated the resident had not required PT services. The PT documented resident #302 was able to transfer and ambulate independently, used a rollator for ambulation and had good mobility of the majority of their extremities and functional strength of major muscle groups. The required action was for physiotherapy staff to regularly monitor the resident and intervene when physical mobility and function declined. The resident was assessed nearly three months later by the PT on a specified date in 2014 after they had experienced five falls. On a specified date in 2014 the PT documented the resident had notable pain in their lower limbs during their assessment and indicated the pain could have resulted from an injury derived from the falls. The PT referred the resident back to nursing and physician for further evaluation.
Interview with the DOC confirmed the PT had not assessed resident #302 after each of their falls and had not ensured the home's Falls Prevention Management Program was complied with when resident #302's falls were not reviewed by the PT until nearly three months after their initial fall.

A review of the clinical record indicated the PT assessed resident #301 post admission and indicated the resident had required PT services related to being at a moderate risk for falls. A referral to the PT was not completed until over one month later, after the resident had experienced three falls with the last fall resulted in in a fracture. The PT documented the resident required 3-6 weeks of non-weight bearing and then weight bearing as tolerated. Interview with the DOC confirmed the PT had not assessed resident #301 after their first two falls and had not ensured the home's Falls Prevention Management Program was complied with when resident #301's falls were not reviewed by the PT until after their third fall which resulted in a fractured pelvis. [s. 8. (1) (a),s. 8. (1) (b)]

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 where the Act or this Regulation requires the licensee of a long-term care home to have, instituted 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, related to their Falls Prevention and Management Program (b) is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents were fully respected and promoted: 4. Every resident had the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

The licensee failed to ensure that resident #402 was cared for in a manner consistent with their needs. Resident #402 had a Cognitive Performance Scale (CPS) score of 6 and was noted to be non verbal, was a two person transfer by mechanical lift, dependent on others for feeding and at low risk for violence/aggression. The resident was totally dependent on others for all of their needs.
A review of the resident's clinical record and progress notes outlined that on a specified day in 2015 the resident was taken to the shower room and they were observed by the staff to have new swelling and bruising. The resident was assessed by the registered staff and the physician was called. The physician stated that it may be a result of an external trauma. The home completed a Critical Incident form, and an investigation was started by the licensee. The physician further assessed the resident and due to the question of physical trauma a x-ray was ordered; the x-ray was negative for fracture. Another physician reassessed the resident and the cause of the injury was not identified.

Interview with the DOC on May 20, 2015 confirmed that something had happened to the resident on the specified day to cause the bruising to the resident but resident abuse was not confirmed. The licensee failed to ensure that the resident was cared for in a manner consistent with their needs when they suffered an injury of unknown origin which resulted in bruising. [s. 3. (1) 4.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions were documented. O. Reg. 79/10, s. 30 (2).

Resident #203 was identified as high risk for Falls and was part of the Home’s “Falling Star” program. During a specific month in 2015, the resident sustained an unwitnessed fall. A Falls Investigation Assessment was completed on the same date and had reported the resident had not sustained any injuries. Review of the clinical record revealed the absence of a physical assessment of the resident, completed by the registered staff , to inform the finding of no injury. Registered staff confirmed the absence of documentation of a physical assessment of the resident that was conducted subsequent to the fall. DOC confirmed they would expect to see documentation of a physical assessment of the resident post fall and that such documentation was absent from the clinical record of resident #203. Actions taken with respect to the resident under a program were not documented. [s. 30. (2)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident’s plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident’s plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident’s plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the restraint plan of care included the alternatives to restraining that were considered, and tried, but had not been effective in addressing the risk.

The plan of care for resident #039 indicated that two, three quarter bed rails were to be used when the resident was in bed. The bed rails were identified as a restraint on the last MDS quarterly assessment in 2015 and staff interviewed confirmed that the bed rails were used to keep the resident in bed. The resident was noted to be a two person transfer for bed mobility but was able to slide to the right on their own. Interview with the DOC on May 13, 2015 confirmed that the plan of care did not include alternatives to restraining that were considered, and tried, but had not been effective in addressing the risk to the resident. [s. 31. (2) 2.]

2. The licensee failed to ensure that the restraint plan of care included an order by the physician or the registered nurse in the extended class.

Resident #039 was noted to have a restraint of two, three quarter bed rails according to the last MDS assessment and plan of care. Interview with the DOC on May 13, 2015 confirmed that the plan of care for this resident did not include an order by the physician or the Registered Nurse in the extended class for bed rails restraint device. [s. 31. (2) 4.]

3. The licensee failed to ensure that the restraint plan of care included the consent by the resident or if the resident was incapable, by the SDM.

Resident #039 was noted to have required the use of two three quarter bed rails when in bed, according to the plan of care, and the last quarterly MDS assessment in 2015. A review of the resident's clinical record, as well as interview with the DOC on May 13, 2015 confirmed that consent had not been obtained from the resident and/or their SDM for the use of the restraint. [s. 31. (2) 5.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was assisted with getting dressed as required, and was dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear.

Resident #004, #005, #204, #205, #016, #017, #032 were residents in their 80's and 90's and were observed during stage one of the Resident Quality Inspection to be awake, dressed in their day time clothes and moving about the home without wearing their personal undergarments. A review of the clinical record was completed for the residents #004, #005, #204, #205, #016, #017, #032 and their plans of care indicated they all had a level of impaired cognition that required assistance with dressing and their dressing goal was for each resident to be dressed appropriately. Interview with a registered staff confirmed that being dressed appropriately would include the residents to be wearing their personal undergarments, beneath their daytime clothing as preferred by the resident. Interview with another registered staff member confirmed that resident #004 and #005 had personal undergarments available however the front line staff would not always assist the residents to put on the undergarment or undershirt. Interview with the DOC confirmed the home did not ensure residents #004, #005, #204, #205, #016, #017, #032 were assisted with getting dressed as required, and were dressed appropriately, suitable to the time of day and in keeping with their preferences. [s. 40.]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when the Family Council had advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee, within 10 days of receiving the advice, responded to the Family Council in writing. 2007, c. 8, s. 60. (2).

During the Family Council interview, the secretary for Family Council advised that when concerns or recommendations were put forward by the Council, a response was received by Council at the following meeting, approximately 30 days later. Review of Family Council meeting minutes revealed the absence of written responses to concerns and recommendations. The Administrator confirmed that when concerns or recommendations were generated from Family Council, a written response was not provided within ten days. [s. 60. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the dining and snack service included a review of the meal and snack times by the Residents' Council. The Administrator confirmed on May 13, 2015, the home had not reviewed the meal and snack times with Resident's Council. [s. 73. (1) 2.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 100. Every licensee of a long-term care home shall ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101. O. Reg. 79/10, s. 100.

Findings/Faits saillants :

1. The licensee failed to ensure that the written procedures required under section 21 of the Act incorporated the requirements set out in section 101.

Regulation 101(3)(a), required that the documented record of complaints kept by the home, was reviewed and analyzed for trends at least quarterly.
The Home's Policy # ADM-VI-18, titled Complaints and dated as reviewed October 2011, directed that the Administrator would ensure that concerns and complaints were tracked by the Quality Manager to determine any common trends or issues. There was no provision that tracking be done quarterly. The Administrator confirmed that the Home's policy had not required that concerns and complaints be tracked at least quarterly. [s. 100.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (3) The licensee shall ensure that,
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that, (c) a written record was kept of each review and of the improvements made in response.

Review of the home's complaints log revealed the absence of a written record of any reviews and improvements made in response. The Administrator confirmed the home had not kept a written record of each review and of the improvements made in response. [s. 101. (3) (c)]

WN #13: 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 ensure that the Director was 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 was taken to the hospital.

A review of the Ministry of Health and Long Term Care Critical Incident Report (CIS) indicated resident #302 had a fall during an identified month in 2015 that required a transfer to hospital. The resident returned to the home a few days later with a diagnosis of a fracture. This injury resulted in a significant change in their status which required pain management and limited weight bearing. The CIS report was submitted 9 days after the licensee had knowledge of the resident's change in status. Interview with the DOC confirmed the licensee had not ensured the Director was informed of the incident in the home no later than one business day after the occurrence of the incident, followed by the report. [s. 107. (3) 4.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that written policies and protocols must be a) developed, implemented, evaluated and updated in accordance with evidenced-based practices and, if there were none, in accordance with prevailing practices.
A review of the home's medication management policies had not included a policy or protocol to manage residents that experienced hypoglycemia or hyperglycemia.
Interview with the DOC confirmed the licensee did not have a policy for managing hypoglycemia and hyperglycemia.

During a month in 2015, resident #403 was noted to have a blood glucose greater than of 20 mmol/L. The home had not performed a re-check of the resident's blood glucose or document any actions taken. Interview with the DOC on May 20, 2015 reported that if a resident's blood glucose was found to be over 20 mmol/L the expectation would be to document any actions taken which included to: push fluids, re-check the resident's blood glucose in one-two hours, and to call the Medical Doctor (MD) if the blood glucose was still elevated. A review of the resident's progress notes had not included any documentation of actions taken that day as confirmed with the DOC. The DOC confirmed that the home did not have a policy for managing hypoglycemia and hyperglycemia until it was brought to their attention by the inspector. [s. 114. (3) (a)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following were other areas in which training shall be provided to all staff who provided direct care to residents: 1. Falls Prevention and Management.

A review of the training and education files for three direct care employees, hired within the last 12 months, were completed. One PSW and one RN employee file did not show evidence of Fall prevention and management training, despite the staff members working with residents that were at risk for falls. The third PSW employee file, did not show they received Falls Prevention and Management training until 4 months after they had been providing direct care to the residents.
Interview with the DOC confirmed the licensee had not ensured training for Fall Prevention and Management was provided to residents as per paragraph 6 of subsection 76 (7) of the Act. [s. 221. (1) 1.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 241. Trust accounts
Specifically failed to comply with the following:

s. 241. (9) Where a written authorization has been provided under subsection (8), the licensee is not required to obtain a written acknowledgement of receipt of funds for every authorized withdrawal, but must include these withdrawals in the quarterly itemized statement under clause (7) (f). O. Reg. 79/10, s. 241 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the authorized withdrawals had been included in the quarterly itemized statement.
As reported by the Resident Support Service Worker on May 14, 2015, the home routinely collected a "recreation fund" in trust for recreational activities such as outings as well as purchases from the tuck shop and specialized lunches for residents. While the home tracked the monies utilized for the resident, a quarterly statement was not issued as per the home admission policy. Interview with the Administrator on May 14, 2015 confirmed that the authorized withdrawals had not been included in a quarterly itemized statement for the resident. [s. 241. (9)]

Issued on this 26th day of June, 2015

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

Original report signed by the inspector.

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) :	ROBIN MACKIE (511), CAROL POLCZ (156), IRENE SCHMIDT (510a)
Inspection No. / No de l'inspection :	2015_250511_0008
Log No. / Registre no:	H-002359-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 26, 2015
Licensee / Titulaire de permis :	BARTON RETIREMENT INC. 1430 UPPER WELLINGTON STREET, HAMILTON, ON, L9A-5H3
LTC Home / Foyer de SLD :	THE WELLINGTON NURSING HOME 1430 UPPER WELLINGTON STREET, HAMILTON, ON, L9A-5H3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LISA BRENTNALL

To BARTON RETIREMENT INC., 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 :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall ensure that where bed rails are used for residents #002, #024 and #039 (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, (a) the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

A) Resident #002 was noted to be sleeping in their bed on a specific day in 2015 with two, half bed rails in place. A review of the resident's clinical record did not indicate the resident was assessed, in their bed in accordance with evidenced-based practice, when bed rails were used in order to minimize risk to the resident.

B) The bed of resident #024 was observed to have one, half rail and one assist rail in the up position, both when the resident was in bed and when the resident was not in bed. Review of the clinical record revealed the absence of resident assessment for bed rails.

C) The bed of resident #039 was observed to have bed rails in the up position. The plan of care for resident #039 indicated that two three quarter rails were to be raised when the resident was in bed. A review of the resident's clinical record did not indicate the resident was assessed, in their bed in accordance with evidenced-based practice, when bed rails were used in order to minimize risk to the resident.

Interview with the DOC on May 11, 2015 confirmed the licensee failed to ensure that where bed rails were used for resident #002, #024 and #039 that they were assessed, in accordance with evidence-based practices and if there were none, in accordance with prevailing practices to minimize risk to the resident taking into consideration all potential zones of entrapment. (511)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 30, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 55. Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Order / Ordre :

The licensee shall ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of resident #208's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among resident #208 and other residents.

Grounds / Motifs :

1. The licensee has failed to ensure that (a) procedures and interventions were developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents;

Resident #208 had a Cognitive Performance Scale (CPS) of 3 and was identified as having a history of physical and verbal aggression related to dementia and anxiety. The Resident Assessment Protocol (RAP) dated January 2015 indicated the resident presented with responsive behavioural and adverse mood behaviours on a daily basis. The RAP further indicated the need for interventions to reduce physical and verbal aggression. Review of the progress notes revealed that in the morning, on a specified day and month in 2015, resident #208 had a number of altercation with two separate residents. Staff intervened in both of these incidents. During the same morning resident #208 was left unattended and unsupervised, when there was an unwitnessed altercation between resident #208 and resident #207, in the hallway in front of their room and the nursing station. When staff responded to the commotion, they found both residents had sustained injuries from the altercation and they required transfer to the hospital. Resident #208 had a fracture and returned to the home. Resident #207 was admitted to hospital with a fracture and other injuries.
Interview with the DOC and registered staff confirmed that the resident had been assessed, it was understood by the home what the primary trigger was for the altercation. The DOC confirmed the resident had demonstrated two episodes of responsive behaviors based on this primary trigger, on the morning in question and that the resident should not have been left unattended in the hallway. Procedures and interventions were not implemented to assist residents who were at risk of harm as a result of a resident's behaviours, including responsive behaviours, and that would minimize the risk of altercations and potentially harmful interactions between and among residents.
(510a)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 30, 2015

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.

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 26th day of June, 2015

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Robin Mackie

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