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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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 1, 2017	2017_577611_0010	008117-17	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

KELLY CHUCKRY (611), CATHIE ROBITAILLE (536), GILLIAN TRACEY (130), YULIYA FEDOTOVA (632)

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): April 25, 26, 27, 28, May 2, 3, 4, 5, 2017.

During the course of this inspection inspector(s) conducted a tour of the home, observed the provision of resident care, reviewed applicable clinical health records, policies, procedures, practices, and investigation notes. Eight Critical Incident inspections, and one on-site inquiry were conducted concurrently with this Resident Quality Inspection. The eight Critical Incident inspections included Log #019140-16, Log #028258-16, and Log #005245-17 pertaining to falls prevention, Log #034953-16 pertaining to medication management, Log #001369-17, and Log 024032-16 pertaining to lift and transfers, Log #008934-17 pertaining to the prevention of abuse and neglect, and Log #007998-17 pertaining to Family Council and the Reporting of Complaints. The one inquiry was Log #034600-16 pertaining to sufficient staffing.

During the course of the inspection, the inspector(s) spoke with residents, family members, the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Food Service Supervisor, Quality Assurance Facilitator, Resident Support Service Manager, Resident Assessment Instrument (RAI) Coordinator, Social Worker (SW), Registered Dietitian (RD), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), dietary aids, and housekeeping aides.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
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
Reporting and Complaints
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **11 WN(s)**
- **6 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (11)	CO #001	2016_341583_0012	130

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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

On an identified date, staff #280 were providing care to resident #103, that involved a transfer of this resident. Staff #280 did not provide safe transferring and positioning techniques during this transfer, and as a result resident #103 sustained an alteration in skin integrity.

The home's policy titled Use of Wheelchairs (NUR-III-51) directed staff on the transferring safety rules, and these were not followed during the transfer.

The DOC acknowledged that staff #280 did not provide safe transferring and positioning techniques for resident #103.

Please note: This non compliance was issued as a result of Critical Incident Inspection #001369-17, which was conducted concurrently with the Resident Quality Inspection. [s. 36.]

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. 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, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with applicable requirements under the Act and in accordance with O.Reg. 79/10, s. 114 (1), that required there be written policies and protocols developed for the medication management system.

The home's policy titled Destruction of Medication Pouches, NUR-V-151, revised June 2014, directed registered staff to: 1. "place an envelope on the medication cart to put the part of medication pouches that contains a resident name on it", 2. "At the end of their shift registered staff member will seal the envelope and shred it".

A) On an identified date, registered staff #310 was observed administering the noon medications. It was observed that staff #310 tore the name from the medication pouch to administer the medications; however, the name and the portion containing the prescribed medications, was disposed with the regular garbage.

Staff #310 was interviewed after the medication pass and acknowledged that the entire medication pouch was disposed of in the regular garbage.
The DOC acknowledged placing the name portion of the pouch in the same garbage as the portion containing the prescribed medications, was not the home's accepted practice and not in keeping with the home's procedure.

The home's policy titled Destruction of Medication Pouches, NUR-V-151, was not complied with. [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, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system is in compliance with and is implemented in accordance with applicable requirements under the Act, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

A) Resident #102 was identified as a risk for falls and as a result, had an intervention in place that was implemented on an identified date.
five days later, the resident sustained a fall, which resulted in injury. The clinical record and the information contained in the CI submitted by the home revealed that some of the interventions implemented were not in working order and not all staff on that day had a working pager on their possession. The information was acknowledged in the CI submitted and in an interview with the DOC on May 3, 2017.

Please note: this non-compliance was issued as a result of CI #005245-17, which was conducted concurrently with the RQI. [s. 15. (2) (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 the home, furnishings, and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff if clinically indicated.

A review of the clinical record for resident #066 revealed that the resident was admitted on an identified date in 2015, with an alteration in skin integrity. The clinical record at the time of the inspection revealed that the resident had two areas of altered skin integrity. A review of the weekly wound assessments revealed that during an identified four month period of time, weekly wound assessments were not completed on five occasions. This was acknowledged by the Skin Care Coordinator. [s. 50. (2) (b) (iv)]

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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff if clinically indicated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area of the medication cart that was secure and locked.

A) On May 3, 2017, an insulin pen containing insulin and a prescription cream were observed on top of the medication cart, on an identified area of the home. The medication cart was unsupervised. The DOC observed the medications on the cart and acknowledged that both the insulin and the prescription cream should have been secured and locked in the medication cart. [s. 129. (1) (a)]

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 are stored in an area of the medication cart that is secure and locked, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a member of the registered nursing staff permitted a staff member who was not otherwise permitted to administer a drug to a resident to administer a topical only if: the staff member had been trained by a member of the registered nursing staff in the administration of topicals.

A) On May 3, 2017, the DOC confirmed that topical prescription creams were applied by PSWs. On May 4, 2017, staff #254 acknowledged they have not receiving training on the application of topical creams and they confirmed they were regularly directed to apply topical creams to residents, by registered staff.

On May 4, 2017, the DOC acknowledged there were no records to confirm that PSWs had received training on the application of the topical creams they were applying.

Not all staff members received training by a member of the registered nursing staff to apply topical creams to residents. [s. 131. (4)]

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 a member of the registered nursing staff does not permit a staff member who was not otherwise permitted to administer a drug to a resident to administer a topical only if: the staff member is trained by a member of the registered nursing staff in the administration of topicals, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's Substitute Decision Maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A) A review of the home's medication incident reports were reviewed over a three month period revealed that the resident, residents' SDMs, if any, the Medical Director, attending physician and pharmacy provider were not consistently notified when there was a medication incident reported.

The DOC acknowledged that the resident, residents' SDMs, if any, the Medical Director, attending physician and pharmacy provider were not consistently notified when there was a medication incident reported, as this was not the home's routine practice. [s. 135. (1)]

2. The licensee failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the last review in order to reduce and prevent medication incidents and adverse reactions, any changes and improvements identified in the review were implemented.

A) The home's Professional Advisory Council minutes were reviewed for the meeting held on April 10, 2017. The minutes revealed that there was not a review or analysis of the 27 recorded medication incidents that had occurred for the three month period prior to the meeting.

The DOC acknowledged that the medication incidents were not reviewed and analyzed at the Professional Advisory Meetings. [s. 135. (3)]

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 every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's Substitute Decision Maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider and that a quarterly review is undertaken of all medication incidents and adverse drug reactions that occur in the home since the last review in order to reduce and prevent medication incidents and adverse reactions, any changes and improvements identified in the review are implemented, to be implemented voluntarily.

WN #8: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 ensure that the plan of care set out clear directions to staff and

others who provided direct care to the resident.

A) The written plan of care for resident #088 revised in January 2017, revealed that an identified method of transfer that was required for this resident, however the MDS quarterly assessment completed in March 2017, stated the resident required a different method of transfer. In April 2017, staff #237 and #276 confirmed the resident required the method of transfer that was identified in the written plan of care. The RAI Coordinator confirmed the MDS Quarterly narrative summary, from March 2017 was inaccurate with reference to transfers.

The plan of care for resident #088 did not provide clear directions to staff related to transfers.

(Please note: this non-compliance was issued as a result of CI inspection : 019140-16, which was conducted concurrently with the RQI. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A review of the plan of care, which the home refers to as the care plan (review was completed in February 2017) for resident #025, identified that the resident required an identified method of transfer for bed transfers. A review of MDS assessment records (completed February 2017) contained information on providing a different method of transfer for bed transfers.

On April 27, 2017, staff #235 indicated that the resident required the method of transfer identified in the MDS assessment. On April 27, 2017, RAI Co-ordinator acknowledged that the care set out in the plan of care for resident #025 was not based on an assessment of the resident's needs completed in February 2017. [s. 6. (2)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) On an identified date, staff #315 was providing care to resident #030 in their bedroom. The written plan of care for this resident revealed an identified method of transfer with two staff members. Staff #315 attempted to transfer resident #030 alone, without the assistance of a second staff member. As a result, an incident occured during this transfer. There was no injury to resident #030 as a result of this incident.

In an interview conducted with the DOC, it was acknowledged that staff #315 did not provide care to this resident as specified in the plan of care as it related to transferring.

Please note : This non-compliance was issued as a result of the following CI #024032-16, which was conducted concurrently with the RQI. (Inspector #611).

B) The plan of care for resident #013, revealed the resident was at risk for falls and required an intervention be in place. On an identified date, staff #256 provided care to this resident, and when the care was completed did not implement the identified intervention. An incident occurred as a result and resident #013 sustained a minor injury.

The DOC acknowledged that resident #013 should have had the identified intervention in place and that care was not provided to the resident as specified in the plan of care.

Please note: This non-compliance was issued as a result of the following CI #038258-16, which was conducted concurrently with the RQI. [s. 6. (7)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to ensure to seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

On May 4, 2017, when the family council chair was interviewed, they revealed that to the best of their knowledge the home did not seek the advice of the Family Council in developing and carrying out the satisfaction survey and in acting on its results. The Inspector then spoke with the home's Social Worker who is the staff liaison to the family council, and they acknowledged that in 2016 it had been done. When preparing the 2017 satisfaction survey they did not seek the advice of the family council in developing and carrying out the 2017 satisfaction survey. [s. 85. (3)]

WN #10: 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,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(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 the documented record (of complaints received) is reviewed and analyzed for trends, at least quarterly.

The complaint log for 2016 and 2016 was reviewed and did not reveal an analysis of trends with respect to the complaints.

The Administrator acknowledged that the documented record of complaints received had not been reviewed and analyzed for trends, at least quarterly.

Please note: This non-compliance was identified during a Compliant Inspection, log# 007998-17, conducted concurrently during this Resident Quality Inspection (RQI). [s. 101. (3)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the infection control program.

The home's policy titled Handwashing Requirements, INF-II-27, revised February 2001, to directed staff to wash their hands, including but not limited to the following: after handling a resident and after touching any areas of a resident.

A) On May 3, 2017, Inspector #130 observed registered staff #310 administer medications to resident's in the dining room. Staff #310 administered oral medications to multiple residents and did a capillary blood glucose check on a resident without sanitizing or washing their hands before or after contact with the residents.

On May 4, 2017, the DOC confirmed it was the home's expectation that registered staff sanitize or wash their hands before and after administering medications and performing capillary blood glucose checks on residents.

On May 3, 2017, staff #310 did not participate in the implementation of the infection control program. (Inspector #130). [s. 229. (4)]

Issued on this 2nd day of June, 2017

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

Original report signed by the inspector.

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY CHUCKRY (611), CATHIE ROBITAILLE (536), GILLIAN TRACEY (130), YULIYA FEDOTOVA (632)
Inspection No. / No de l'inspection :	2017_577611_0010
Log No. / Registre no:	008117-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 1, 2017
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)

Linked to Existing Order / Lien vers ordre existant: 2016_341583_0012, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall ensure that the following is completed: 1. Ensure all residents who require assistance with transfers, including resident #103, are transferred as directed in their plan of care using safe transferring and positioning devices and techniques. 2. Ensure all direct care staff are re-educated on how to use transferring devices and how to preform safe transferring and positioning techniques, including education the Use of Wheelchairs policy NUR-III-51, 3. Ensure there is an auditing process to monitor ongoing compliance related to i) staff using the correct transferring devices ii) staff using the correct transferring techniques, specifically ensuring all residents who require assistance from two staff are transferred by two staff members.

Grounds / Motifs :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

The Order is made based upon the application of the factors of severity (2 - minimal harm), scope (1 - isolated) and compliance history (4 -ongoing non compliance with an order), and the Licensee's history of noncompliance with a CO on August 22, 2016.

On an identified date, staff #280 were providing care to resident #103, that involved a transfer of this resident. Staff #280 did not provide safe transferring and positioning techniques during this transfer, and as a result resident #103 sustained an alteration in skin integrity.

The home's policy titled Use of Wheelchairs (NUR-III-51) directed staff on the transferring safety rules, and these were not followed during the transfer.

The DOC acknowledged that staff #280 did not provide safe transferring and positioning techniques for resident #103.

Please note: This non compliance was issued as a result of Critical Incident Inspection #001369-17, which was conducted concurrently with the Resident Quality Inspection. [s. 36.] (611)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 01, 2017

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 1st day of June, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kelly Chuckry

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