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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 28, 2017	2017_700536_0023	026590-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD P.O. Box 344 THOROLD ON L2V 3Z3

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

THE WOODLANDS OF SUNSET
920 PELHAM STREET WELLAND ON L3C 1Y5

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

CATHIE ROBITAILLE (536), CATHY FEDIASH (214), LISA BOS (683)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): November 28, 29, 30, December 1, 4, 5 and 6, 2017

The following inspections were completed concurrently with the Resident Quality (RQI) Inspection.

Critical Incident System Reports:

027529-17-pertaining to: Fall Prevention
004025-17-pertaining to: Hazardous Substances
021130-17-pertaining to: Nutrition and Hydration

Complaints:

033097-16-pertaining to: Nutrition & Hydration, Personal Support Services

During the course of the inspection, the inspector(s) spoke with residents, family members, personal support workers (PSW's), registered staff, dietary staff, Dietary Manager, Registered Dietitian (RD), Program and Services Co-Ordinator, Maintenance Co-Ordinator, Physiotherapist, Resident Assessment Instrument-Minimum Data Set Co-Ordinator(RAI-MDS), Assistant Director of Resident Care (ADRC), Director of Resident Care (DRC) and the Administrator.

During the course of the inspection, the inspector(s) toured the home, observed meal and snack services, observed the provision of care and services provided on all home areas, interviewed staff, residents and families, and reviewed relevant documents including, health care records, investigation reports, training records, meeting minutes, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

- **3 WN(s)**
- **2 VPC(s)**
- **1 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 LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

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

A) A review of the home's Critical Incident System (CIS) report and staff interviews identified that on an identified date, that resident #008 was not looking well. The PSW alerted Registered Nurse (RN) #113, who was on duty at the time, who then informed RN #100 and they responded to the situation, which resulted in a change in the resident's health status.

Resident #008's clinical record identified they were on an identified diet. On an identified date the resident did not receive the specified diet and texture as ordered, and in their plan of care. Interview with the Dietary Manager identified that it was the responsibility of the dietary aide to provide the specified diet and texture for each resident. They noted that the dietary aides had a copy of the Meal Distribution Report which included required needs for all residents.

The Dietary Manager confirmed that the care set out in the plan of care was not provided to the resident as specified in the plan. (Inspector #683)

PLEASE NOTE: This area of non compliance was identified during a CI inspection, log # 021130-17, conducted concurrently during this RQI.

B) A review of resident #004's clinical records including a Minimum Data Set (MDS) significant change in status assessment; corresponding narrative Resident Assessment Protocol (RAP), and an initial Wound Care Assessment in Point Click Care (PCC) all on identified dates indicated that the resident had an area of altered skin integrity.

A review of the resident's written plan of care in place at the time of this inspection indicated under the focus of potential for skin integrity breakdown, that staff were to follow an identified intervention. A review of the Point of Care (POC) task identified that the identified intervention was to be in place at all times.

On an identified date in 2017, resident #004 was observed by registered staff #100, and the Inspector to not have the specified intervention in place. Registered staff #100 confirmed that the care set out in the plan of care had not been provided to resident #004 as specified in the plan. (inspector #214) [s. 6. (7)]

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. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home are kept inaccessible to residents at all times.

A Critical Incident System (CIS) report was submitted to the Director in 2017, indicated that a identified hazardous substance had been left in resident #009's room. At an identified time that same day staff #114 found the identified hazardous substance in resident #009's room. The resident was unable to communicate if they had contact with the hazardous substance. On an identified date in 2017, staff #108 confirmed they had left the hazardous substance in the resident's room. Again on an identified date in 2017, both staff #108 and #114 confirmed that the identified solution should not have been accessible to residents.

PLEASE NOTE: This area of non compliance was identified during a CI inspection, log # 004025-17, conducted concurrently during this RQI. [s. 91.]

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 and ensuring that all hazardous substances at the home are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #3: 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 any plan, policy, protocol, procedure, strategy or system was complied with.

O. Reg. 79/10, s. 68 (1) (a) identifies that this section and sections 69 to 79 apply to the organized program of nutrition care and dietary services required under clause 11 (1) (a) of the Act, which identifies that every licensee of a long-term care home shall ensure that there is an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents.

A review of the home's policy number DAT03-016 "Temperature, Presentation, Taste Recording," last reviewed May 15, 2015, indicated the following:

i) Mandatory recording of food temperature in kitchen prior to meal service.
ii) Monitoring of food temperatures at point of service to avoid risk of burns to residents by serving food at safe temperatures. Beverages/soup served 170 to 190 degrees Fahrenheit; creamed soups 149 to 167 degrees Fahrenheit.

A complaint was filed with the Ministry of Health and Long Term Care (MOHLTC) which identified that on two occasions it was believed that resident #010 had suffered an injury from food that was too hot. Lunch was observed by the Inspector on an identified date. After the meal was served, the Inspector requested the temperature log from dietary aide #118, who identified that they took the temperatures of the food prior to meal service; however, they could not find the temperature report to document the temperatures.

Dietary aide #118 found the temperature report and recorded the temperatures that were measured prior to meal service. Upon review of the "Pre Meal Temperature Report," the Inspector identified there were no temperatures recorded on identified dates in 2017, and the temperatures of specified foods were recorded as identified degrees Fahrenheit.

Interview with the Dietary Manager, identified that the temperatures were not documented on the identified dates in 2017, because the temperature reports were not printed. They also identified that it was the responsibility of dietary aide #118 to record the temperatures of the food, and that they should have documented the food temperatures prior to meal service. The Dietary Manager further acknowledged that if identified food/fluids had temperatures that were out of range, then they should have been re-measured and documented at the point of service to ensure they were within the appropriate range, prior to serving to the residents. They identified and confirmed that the current documentation available in the home did not allow the dietary staff to record the temperatures of the identified food/fluid items at the point of service to avoid the food/fluids being served at inaccurate temperatures. They acknowledged that they had recently identified the home was not in compliance with their policy and that they were about to implement a new documentation practice which allowed for point of service temperature documentation.

The home did not ensure that their "Temperature, Presentation, Taste Recording" policy was complied with.

PLEASE NOTE: This area of non compliance was identified during a Complaint inspection, log # #033097-16, conducted concurrently during this RQI. [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 and ensuring that any plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

Issued on this 9th day of January, 2018

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) :	CATHIE ROBITAILLE (536), CATHY FEDIASH (214), LISA BOS (683)
Inspection No. / No de l'inspection :	2017_700536_0023
Log No. / No de registre :	026590-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 28, 2017
Licensee / Titulaire de permis :	THE REGIONAL MUNICIPALITY OF NIAGARA 2201 ST. DAVID'S ROAD, P.O. Box 344, THOROLD, ON, L2V-3Z3
LTC Home / Foyer de SLD :	THE WOODLANDS OF SUNSET 920 PELHAM STREET, WELLAND, ON, L3C-1Y5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tracey Tait

To THE REGIONAL MUNICIPALITY OF NIAGARA, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall:

1) Ensure that the care set out in the plan of care for diet texture is provided to all residents as specified in the plan.
2) Review job descriptions and roles with dietary aide #102.
3) Retrain dietary aide #102 on providing appropriate diet textures to all residents, as identified in their care plans.

Grounds / Motifs :

1. The Order is made based upon the application of the factors of severity (3), scope (1) and compliance history (4), in keeping with s. 6 (7) of the Act, in respect of the actual harm for resident #008, the scope of the issue was isolated, and the Licensee's compliance history of a VPC in August 2015.

A review of the home's Critical Incident System (CIS) report and staff interviews identified that on an identified date, that resident #008 was not looking well. The PSW alerted Registered Nurse (RN) #113, who was on duty at the time, who then informed RN #100 and they responded to the situation, which resulted in a change in the resident's health status.

Resident #008's clinical record identified they were on an identified diet. On an identified date the resident did not receive the specified diet and texture as ordered, and in their plan of care. Interview with the Dietary Manager identified that it was the responsibility of the dietary aide to provide the specified diet and texture for each resident. They noted that the dietary aides had a copy of the Meal Distribution Report which included required needs for all residents.

The Dietary Manager confirmed that the care set out in the plan of care was not provided to the resident as specified in the plan. (Inspector #683)

PLEASE NOTE: This area of non compliance was identified during a CI inspection, log # 021130-17, conducted concurrently during this RQI.

(683)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 18, 2018

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 28th day of December, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cathie Robitaille

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