Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 12, 2014	2014_210169_0020	H-001216-14	Resident Quality Inspection

Licensee/Titulaire de permis

REGENCY LTC OPERATING LP ON BEHALF OF REGENCY
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

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

THE WENLEIGH
2065 Leanne Boulevard, MISSISSAUGA, ON, L5K-2L6

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

YVONNE WALTON (169), KATHLEEN MILLAR (527), MELODY GRAY (123)

Inspection Summary/Résumé de l'inspection

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

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

This inspection was conducted on the following date(s): September 16-26, 2014 (4W)

The following complaint log H-00291-14 and critical incidents log H-00875-14, H-001564-14 H-00462-14 were completed during this Resident Quality Inspection. H-000460-14.

During the course of the inspection, the inspector(s) spoke with residents, families, nursing staff, dietary staff, housekeeping staff, administrator, director of care, Assistant director of care, RAI coordinator, food service manager, dietitian, program and support service manager and environmental staff.

During the course of the inspection, the inspector(s) observed all care areas and care provided, reviewed clinical records, reviewed minutes of meetings and policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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.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. (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 :

The licensee has failed to ensure that that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Based on the resident's MDS assessment resident #009 requires extensive assistance for personal hygiene. The documents which the staff use to direct care for resident #009, called the care plan and kardex, did not identify the oral and dental needs of the resident. The Long Term Care (LTC) Inspector reviewed the care plan and kardex with the PSWs and registered staff, they confirmed the plan of care was not clear as to what oral and dental care was to be provided to the resident. [s. 6. (1) (c)]

3. The licensee has failed to ensure that Resident #600 received the care as set out in the plan of care related to falls prevention. The plan of care directed staff to ensure the bed is put into the lowest position with a crash pad beside the bed. Observation revealed the resident was very restless in bed and the bed was not in the lowest position. The clinical documentation and nursing staff confirmed the bed was not in the lowest position putting the resident at risk of falling. [s. 6. (7)]

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 that ensures there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to all residents and the care set out in the plan of care is provided to all residents as specified in the plan,, to be implemented voluntarily.

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 :

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with?

Resident #009 requires extensive assistance to perform oral and dental care. The registered staff, the ADOC,and the PSWs confirmed the PSWs were expected to provide or assist with oral and dental care at least two times per day for the resident. The home's policy called "LTC Care Staff Guide Book", dated September 2014, pages 46-47, states that oral and dental care was to be performed at least twice per day. The review of the clinical record revealed that the resident was not provided with oral and dental care in the morning and evening. The registered staff, the PSWs and the ADOC confirmed the resident did not receive oral and dental care in the morning and evening. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee failed to ensure that the policy of Resident Abuse was complied with.

Concerns were raised that resident #009 was physically and verbally abused. The home acknowledged the concern and initiated an investigation. The home's policy called "Resident Abuse, number RCA-LTCE-E-02 RCAM-IV-15" was last revised on April 2013 states abuse reporting is mandatory; all staff members are required to report any abuse or allegation of abuse immediately to the Administrator, Director of Care or Director of Resident Services Manager or designate. The person receiving the report was to report the allegation to the provincial Ministry of Health and Long Term Care (MOHLTC) by phoning the duty inspector immediately on the day of the report and follow up with a Critical Incident Summary (CIS). The alleged abuse of resident #009 was not reported to the Director as expected in the home's policy. The ADOC, the Director of Resident Services and the Administrator confirmed that the allegation of abuse for resident #009 was not reported to the Director as outlined in the home's policy. [s. 8. (1) (b)]

The home's April, 2014 Complaint Log was reviewed and included documentation related to a verbal complaint received by the home which included an allegation of abuse of an identified resident #100 which was not reported to the MOHLTC as per the home's policies and procedures. The Administrator and Director of Care (DOC) were interviewed and they confirmed that the alleged abuse was not reported to the MOHLTC as per the home's policies and procedures.

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 that ensures 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 is in compliance with and is implemented in accordance with all applicable requirements under the act: and is complied with, 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 has failed to ensure that furnishings in the common areas for residents in all homes areas are kept clean. Observation on Sept 16, 17 and 19, 2014 revealed several pieces of lounge furniture was visibly soiled throughout the entire home.
In the Clock tower lounge a purple love-seat was visibly stained, the Country club lounge had a blue Queen Anne chair that was visibly stained, second floor lounge chairs are visibly soiled, Port Credit lounge had yellow Queen Anne chairs and a pink chair that were visibly soiled. Confirmed with the Administrator and Director of Care. [s. 15. (2) (a)]

2. The licensee has failed to ensure that handrails are in a good state of repair throughout the entire home. Some areas were observed September 16, 17 and 19, 2014 to have paint chipped and some areas had gouges and sharp edges throughout the home areas.
Wall damage was observed throughout the home in several resident rooms including spa area on Port Credit, shower area on third floor, grout in several showers was observed to be black, sit to stand lifts on all three floors has a broken knee pad area and hand grips are broken and soiled, carpet on third floor between room 351-354 is bubbling creating an unsafe condition, ceiling tiles in common entrance halls stained, third floor shower room has a shower chair with ripped vinyl and foam exposure (approximately 3 inches by 2 inches) and the drawers in the kitchen on Port Credit home area have chipped laminate facing. Confirmed with Administrator and Director of Care. [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 that ensures the home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #4: 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure all residents are provided privacy when caring for their personal needs. Throughout the home the shower and tub rooms were not equipped with privacy curtains, resulting in residents being seen from the hallway if the door is opened. Examples included Port Credit did not have privacy curtains around the shower area, on third floor the shower area only had a short curtain which did not provide complete privacy around the shower, the jacuzzi room did not have privacy curtains around the toilet area, on second floor the spa area had curtains but they were not secured to the track, the jacuzzi with the Liberti tub was not equipped with any privacy curtains, Orchard Heights had privacy curtains in the spa area but they were falling down in spots and not providing full privacy to residents. This was confirmed by staff. [s. 3. (1) 8.]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. At a minimum, the policy to promote zero tolerance of abuse and neglect of residents, (a) shall provide that abuse and neglect are not to be tolerated; (b) shall clearly set out what constitutes abuse and neglect; (c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; (d) shall contain an explanation of the duty under section 24 to make mandatory reports; (e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; (f) shall set out the consequences for those who abuse or neglect residents; (g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and (h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Concerns related to potential physical and verbal abuse of Resident #009 were raised. The home initiated an immediate investigation, however they did not immediately report to the Director of a suspected abuse of a resident. There was no critical incident report located in the MOHLTC Critical Incident System (CIS), and the home had no CI in their log book. This was confirmed by the ADOC, the Director of Resident Services and the Administrator. [s. 20. (2)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee immediately forwarded any written complaints that have been received concerning the care of a resident or the operation of the home to the Director. The home's 2014 complaint log was reviewed and The Director of Care (DOC) were interviewed and they confirmed that the home did not forward the written complaint to the Director. [s. 22. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #009 received oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening, and/or cleaning of dentures.

Resident #009 requires extensive assistance to perform oral and dental care. The registered staff, the ADOC,and the PSWs confirmed they are expected to provide or assist with oral and dental care at least two times per day for the resident. The home's policy called "LTC Care Staff Guide Book", dated September 2014, pages 46-47, states that oral and dental care was to be performed at least twice per day. The review of the clinical record revealed that the resident was not provided with oral and dental care in the morning and evening from September 1 to 15, 2014. The registered staff, the PSWs and the ADOC confirmed the resident did not receive oral and dental care in the morning and evening. [s. 34. (1) (a)]

WN #8: 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:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that food was served at a temperature that was palatable to the residents. Observation of food temperatures on September 24, 2014 noon meal revealed the food temps were only 51 degrees for the pureed carrots at 1230 hours. The steam table was not able to maintain a temperature of greater than 60 degrees throughout the meal. The food service manager confirmed the finding. [s. 73. (1) 6.]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

Reviewed the home's training records for annual retraining of employees related to the Residents' Bill of Rights; the home's policy to promote zero tolerance of abuse and neglect of residents; the duty to make mandatory reports under section 24; and the whistle-blowing protections. In 2013 not all employees received retraining. The total number of employees who should have received retraining were 219 and out of that number only 158 (72%) employees were trained. This was confirmed by the Director of Resident Services and the Administrator. [s. 76. (4)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

Resident #009 reported that the staff was rough and yelling at them. The home immediately initiated the investigation and were not able to substantiate verbal or physical abuse of resident #009. The home did not notify the resident or substitute decision maker of the results of the alleged abuse investigation. There was no documentation of the communication in the resident's clinical record. There was no complaint log documented. There was no critical incident submitted to the Director. The ADOC, the Director of Resident Services and the Administrator confirmed the alleged abuse was not reported immediately to the Director, that it was not documented in their Complaint log, and that there was no documentation of the notification to the resident or SDM of the outcome of the alleged abuse investigation. [s. 97. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply

Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

1. All areas where drugs are stored shall be kept locked at all times, when not in use.

2. Access to these areas shall be restricted to,

i. persons who may dispense, prescribe or administer drugs in the home, and

ii. the Administrator.

3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

The licensee has failed to ensure that all areas where drugs are stored are kept locked at all times, when not in use.

The LTC Inspector observed the medication carts unlocked on Credit Valley unit on September 19 and September 22, 2014. The medication cart was in the hallway outside residents' rooms on September 19, 2014 when it was left unlocked and the registered staff and student nurse were in a resident's room. On September 22, 2014 the cart was at the entrance of the dining room when the medication cart was left unlocked. On both occasions the medication carts were left unlocked, unattended and out of of visual range of the registered staff. The registered nurse and student nurse confirmed the medication cart was left unlocked. [s. 130. 1.]

Issued on this 12th day of November, 2014

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