Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Inspection Report under the LTC Homes Act, 2007 X Public Copy Licensee Copy	**Rapport d'inspection prevue de le Loi de 2007 les foyers de soins de longue durée** Copie du Titulaire X Copie de la Publique	
Date(s) of inspection/Date de l'inspection August 17, 2010	**Inspection No/ d'inspection** 2010-168-2861-16Aug17829	**Type of Inspection/Genre d'insptection** Other – Critical Incident H-00832
Licensee/Titulaire Waterdown Long-Term Care Centre Inc. 689 Yonge Street Midland ON L4R 2E1		
Long-Term Care Home/Foyer de soins de longue durée Alexander Place 329 Parkside Drive P.O. Box 50 Waterdown ON L0R 2H0		
Name of Inspector(s)/Nom de l'inspecteur(s) Lisa Vink		

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé.

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.)

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct an Other – Critical Incident Inspection

The inspection was conducted by Lisa Vink, #168.

The inspection occurred on August 17, 2010.

During the course of the inspection, the inspector spoke with:
The Administrator, Nursing Manager/Staff Educator and front line nursing staff

The following Inspection Protocols were used during this inspection:
Fall Prevention
Pain

2 Findings of Non-Compliance were found during this inspection. The following action was taken:
2 WN
1 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Plan of correction/Plan de redressement
DR – Director Referral/Régisseur envoye
CO – Compliance Order/Ordres de conformité
WAO – Work and Acitvity Order/Ordres: travaux et activitiés

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé.

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.)

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

WN#1: The Licensee has failed to comply with: LTCHA, 2007, S.O. 2007, c.8, s6(1)(c)
The licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

Findings:

1. The specified resident was recently assessed to require a mobility device. The need of this mobility device and the staff intervention associated were not included on the document staff refers to as the Care Plan. The resident recently fell, at which time care needs changed from being independent with some activities of daily living to requiring total staff assistance with toileting and transferring. The Care Plan was not updated to reflect these changes in the resident's care needs.
2. The residents Care Plan has not been updated to reflect changing need related to pain management since the fall.

VPC – Pursuant to LTCHA, 2007, S.O. 2007, c. 8, s.152(2) the licensee is hereby requested to prepare a written plan or correction for achieving compliance with s. 6(1)(c) in respect to ensuring that the resident plan of care sets out clear direction to staff providing care. This is plan is voluntary.

Inspector ID#: 168

WN#2: The Licensee has failed to comply with: O. Reg. 79/10, s. 52(2)

The licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Findings:

1. The specified resident was ordered a narcotic, as needed, post fall, to manage symptoms of pain and this medication was increased to three times a day two days later; however no pain assessment instrument was utilized to assess the resident at this time.

Inspector ID#: 168

Signature of Licensee of Designated Representative **Signature du Titulaire du représentant désigné**		**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** October 12-2010
Title:	**Date:**	**Date of Report (if different from date(s) of inspection).**