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

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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 10, 2015	2015_323130_0006	H-002128-15	Complaint

Licensee/Titulaire de permis

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 ou des inspecteurs

GILLIAN TRACEY (130)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 18, 2015

During this inspection staff were interviewed and clinical records, relevant policies and investigation notes were reviewed.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC) and the resident's Power of Attorney (POA).

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
2 VPC(s)
0 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.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A) On an identified date in 2015 resident #001 was admitted to the home from Facility B. The registered staff on duty received a copy of the electronic medication record (E-MAR) from Facility B and used this record to complete the medication reconciliation.

The E-MAR received from Facility B was a poor quality copy of the original document, which rendered it difficult to read as a number of shaded areas disguised the identity of a number of medication orders.

The DOC confirmed that the registered staff did not seek clarification from Facility B regarding the E-MAR copy despite its poor quality nor did they seek clarification when the medication strip packaging and a card of medication received from the POA, did not match their reconciled medication list. As a result, the medications in the shaded areas of the document were not transcribed to the admission orders.

On an identified date in 2015, following their admission, the resident was transferred to the hospital following a medical emergency at the home.

The home's internal investigation concluded, since admission, the resident had missed eight doses of an identified medication and five doses of another.

The Administrator confirmed that registered staff did not obtain consent from the POA, for the medication strip packages, the card of medication nor the medications identified on the admission medication list, provided by Facility B.

The POA was not given the opportunity to be involved in the development of the plan of care. [s. 6. (5)]

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, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker is given an opportunity to participate fully in the development and implementation of the resident's plan of care, 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 :

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

The home's policy titled: "Resident Rights, Care and Services - Medication Management - Medication Reconciliation", dated October 7, 2013, indicated:

During admission, registered staff would obtain the admission medical orders from the attending physician based on the transferring paperwork or upon the information received from the resident or the Power of Attorney (POA) for personal care and registered staff would attempt to clarify any discrepancies.

A) On an identified date in 2015, resident #001 was admitted to the home from Facility B. The registered staff on duty received a copy of the electronic medication record (E-MAR) from Facility B and used this record to complete the medication reconciliation. The E-MAR received from Facility B was a poor quality copy of the original document, which rendered it difficult to read as a number of shaded areas disguised the identity of a number of medication orders.

The home confirmed that on the day of admission, the POA gave the registered staff the medication strip packages and a card of medication, provided by Facility B.

The DOC confirmed that the registered staff did not seek clarification regarding the E-MAR copy despite its poor quality nor did they seek clarification when the medication strip packaging and card of medication received from the POA, did not match their reconciled medication list. As a result, the medications in the shaded areas of the document were not transcribed to the admission orders.

On an identified date in 2015, following their admission, the resident was transferred to the hospital following a medical emergency at the home.

The home's internal investigation concluded, since admission, the resident had missed eight doses of an identified medication and five doses of another.

The DOC confirmed that staff did not comply with the home's policy: Medication Management - Medication Reconciliation. [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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, to be implemented voluntarily.

Issued on this 10th day of June, 2015

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

Original report signed by the inspector.