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

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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
Mar 9, 2015	2015_344586_0003	H-002018-15	Resident Quality Inspection

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

JESSICA PALADINO (586), MARILYN TONE (167), MELODY GRAY (123), YVONNE WALTON (169)

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): February 19, 20, 23, 24, 25, 26, 27, March 3, 4, 5 and 6, 2015.

This inspection was conducted concurrently with Critical Incident Inspections H-001819-15 and H-001926-15; and Complaint Inspections H-001062-14 and H-001366-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Directors of Care (Co-DOC), Restorative Care Co-ordinator, Maintenance Supervisor, Staff Educator, Staffing Co-ordinator, registered nursing staff, laundry staff, dietary staff, Personal Support Workers (PSW's), residents and family members.

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
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

9 WN(s)
4 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. 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to be treated with courtesy and respect.

i. During an interview with Inspector #169 on an identified date in February 2015, resident #017 revealed that a particular PSW was rough with them during care. Follow-up interview with Inspector #586 on an identified date in March 2015 revealed that the resident and their family member did not have any concerns of physical abuse; however, felt the staff member rushed during care. The resident reported that they had told the staff member on multiple occasions that they were being too rough, and that the staff member did not listen.
ii. During an interview on an identified date in March 2015, resident #206 revealed that they also felt this staff member was rough during care due to rushing. The resident reported an incident where they told the staff member they were going too fast and the staff member did not slow down.
iii. During an interview on an identified date in March 2015, resident #205 revealed that they also felt this staff member was rough during care due to rushing.
iv. Interview with a Co-DOC on an identified date in March 2015 and review of the incident file revealed that the staff member was currently being investigated on co-worker complaints. [s. 3. (1) 1.]

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 every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #2: 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. (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).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for resident #016 that sets out clear directions to staff and others who provide direct care to the resident.

Resident #016 was at high risk for falls as evidenced by their plan of care.
i) The resident's kardex, which front-line staff use to be kept aware of the resident's care needs, indicated the use of a bed alarm. Interview with direct care staff, a Co-DOC, and the Administrator confirmed that the resident no longer used a bed alarm. The Administrator confirmed that in place of a bed alarm, the staff were to take the resident's

personal alarm off of their wheelchair and attach it to the resident's bed when in bed.
ii) The resident fell out of their bed on an identified date in February 2015 and sustained a minor injury. A Co-DOC spoke with the PSW who put the resident to bed that night who confirmed that the personal alarm was in place; however, it did not activate. The PSW indicated that they were unclear on how to most effectively attach the personal alarm to the resident's bed to ensure activation.
iii) The resident's documented plan of care indicated the resident was to have their personal alarm on at all times; however, there was no direction for staff to detach the personal alarm from the resident's chair and place it onto their bed in place of a bed alarm. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care for resident #023 was based on an assessment of the resident and the resident's needs and preferences.

The plan of care of identified resident #023 specific to falls was reviewed. It included that the resident forgets that they can no longer walk and that the resident needed a personal alarm on at all times.
i. The documentation in the resident's record noted that the resident was assessed by the physiotherapist in September 2014 and it was noted that the resident transferred and ambulated independently.
ii. The resident #023 was observed and they were able to ambulate using a wheeled walker and did not have a personal alarm on. A front-line staff member was interviewed and they confirmed that the resident was able to walk using a wheeled walker and that a personal alarm was not used in the resident's care. A registered staff member was interviewed and they also confirmed that the resident was able to ambulate and that the resident did not use a personal alarm in their care as noted in the care plan.
iii. The care plan for resident #023 did not state that the resident could walk using a wheeled walker and that they did not need a personal alarm at all times. [s. 6. (2)]

3. The licensee has failed to ensure that resident #016's substitute decision-maker (SDM) was given the opportunity to participate fully in the development and implementation of the resident's plan of care.

i) Interview with the home's DOC revealed that the home was in the process of reducing bed rail use throughout the home. During stage I of the RQI on an identified date in February 2015, resident #016's SDM entered the resident's room with Inspector #169 to discover that the bed rails had been removed from the resident's bed and the SDM confirmed they were not aware of this happening.

ii) Resident #016's documented plan of care indicated the use of two bed rails when the resident was in bed.
iii) Review of the resident's health care records revealed there was no physician's order for the removal of the bed rails.
iv) On an identified date in February 2015, the resident fell from their bed and suffered a minor injury. The Fall Incident Note indicated that the suspected cause of the fall was the resident shifting in bed and slid off due to lowered bed rails.
v) Interview with the Restorative Care Co-ordinator confirmed that resident #016's bed rails were removed prior to consent from the resident's SDM, and confirmed that this change to the resident's plan of care should have been discussed with the SDM prior to making the change. [s. 6. (5)]

4. 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.

The plan of care for resident #300 was reviewed and it was noted that the resident required the use of a mechanical lift for all transfers. The home's internal investigation records and the resident's records were reviewed and indicated that the resident was not transferred using a mechanical lift but was transferred as a two-person lift. Interview with the DOC on on an identified date in March 2015 confirmed that the staff did not transfer the resident as per the resident's plan of care and that actions were not taken by the home as per the home's policies and procedures. The home failed to ensure that resident #300 was transferred as per their plan of care. [s. 6. (7)]

5. The licensee has failed to ensure that resident #016's plan of care was reviewed and revised when the residents' care needs changed or care set out in the plan was no longer necessary.

Resident #016 was at high risk for falls and experienced multiple falls in 2014 as per the plan of care and Fall Committee meeting minutes. The resident's kardex, which front-line staff use to be kept aware of the resident's care needs, and task list, where the staff document the care provided, indicated the use of a bed alarm. Interview with front-line staff and a Co-DOC confirmed the resident no longer used a bed alarm, and the Co-DOC confirmed the plan of care was not updated. [s. 6. (10) (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 the care set out in every resident's plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident was protected from verbal abuse by anyone.

i. During an interview on on an identified date in March 2015, resident #017 and their family member reported that they had told a staff member on multiple occasions that they were rushing and being too rough during care, and that the staff member did not listen and responded to the resident by saying "don't tell me I'm rough".
ii. During an interview on an identified date in March 2015, resident #206 reported an incident where they told the same staff member they were going too fast during care and the staff member responded by saying "let me do my job" and "don't shake your finger at me".
iii. During an interview on an identified date in March 2015, resident #205 reported an incident where they told the same staff member they were rushing and hurting them, and the staff member responded by saying they were not being rough. The resident stated they felt angry because of the occurrence.
All residents indicated they had not reported the incidences to the home. Interview with the Co-DOC and Administrator confirmed they were unaware of the incidences. [s. 19. (1)]

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 every resident is protected from verbal abuse by anyone, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure the home had a staffing plan in place that included;
d) a back-up plan for nursing and personal care staffing that addressed situations when staff, including the staff who must provide that nursing coverage required under subsection 8(3) of the Act, cannot come to work.

During resident interviews throughout Stage I of the RQI inspection, it was identified by a number of residents that the home often works short without a full complement of nursing staff.
i. A review of the Residents' Council minutes dated January 2015 confirmed that the resident's were concerned about staff shortages.
ii. During a review of the staffing patterns at the home, it was noted that there were 15 personal support worker shifts that the home was not able to replace between December 29,2014 and February 21, 2015.
iii. During an interview with the Administrator, they indicated that the home was currently working on a contingency plan for staffing that is still in draft form and has not yet been approved. The draft plan included processes to follow related to registered staff and PSW staff shortages. Currently the home does not have a written contingency plan in place.
iv. During an interview with the Staffing Coordinator, it was confirmed that the home had worked short on a number of occasions lately. It has not been possible to replace staff on those occasions. [s. 31. (3) (d)]

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 the home has a staffing plan in place that included a back-up plan for nursing and personal care staffing that addressed situations when staff including the staff who must provide that nursing coverage required under subsection 8(3) of the Act, cannot come to work, to be implemented voluntarily.

WN #5: 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 has failed to ensure that the home's falls prevention and management policy was complied with.

Resident #201 experienced multiple falls in January 2015 and resident #016 experienced a fall in February 2015. The home's policy "Falls Prevention and Management Program" (last revised November 11, 2014) directed staff to complete a post-fall worksheet and risk form after a resident has fallen. Review of resident #201's and #106's health records revealed these forms were not completed post-fall. Interview with a Co-DOC confirmed that the staff were no longer required to complete these forms; however, the policy had not been updated to reflect the home's current process, therefore the staff were not following the current policy. [s. 8. (1) (a),s. 8. (1) (b)]

WN #6: 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 the home's equipment was maintained in a safe condition and in a good state of repair.

On March 3, 2015, the bedroom call bell cords in two resident rooms were observed to have exposed wires. The bed control cords in three resident rooms were observed to be significantly frayed with most of the cord's wires exposed. Interview with front-line staff confirmed the damaged cords had been reported to the maintenance department on multiple occasions over the past several months through verbal exchange as well as through using the Maintenance Log Book. Review of the log book records confirmed damaged cords were reported. Interview with the Maintenance Supervisor on an identified date in March 2015 confirmed the cords were not in a good state of repair. [s. 15. (2) (c)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all special treatments and interventions were included in the plan of care for resident #028.

A) During observation of resident #028 on two identified dates in February 2015, it was noted that the resident was using a specific PASD.
i. During a review of the document that the home referred to as the care plan for resident #028, it was noted that the care plan did not include the use of the specific function of the PASD or the reason for it's use.
ii. During an interview with the DOC and the Restorative Care Co-ordinator, it was confirmed that staff at the home were not routinely indicating in the resident's plan of care if the resident was using specific PASD or the purpose for their use, unless the function was being used as a restraint to prevent injury.
iii. During interviews with staff, they were not able to provide a reason for the use of the PASD for the resident.

B) Resident #035 used two specific PASD's as evidenced by observation and interview with the resident on two identified dates in February 2015. There was no indication of the use of these interventions in the resident's documented plan of care, including the reasoning behind their use. Interview with the DOC confirmed they were unsure of the exact reasoning for the use of the devices but thought that they may have been used as a PASD. The DOC also confirmed that the home did not include the use of these PASD's in residents' documented plans of care. (586) [s. 26. (3) 18.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a record was kept up to date of care conferences held for residents #006 and #012 including the date of the conference, the participants and the results of the conference.

A) During a review of the health file for resident #006, it was noted that a care conference was held on an identified date in February 2015. Documentation related to the conference was completed by dietary and restorative care; however, there was no documentation to indicate that any other discipline attended, nor was there evidence to indicate that the resident's plan of care was reviewed related to nursing or recreation. There was no indication of who attended the conference.

B) During a review of the health file for resident #012, it was noted that a care conference was held on an identified date in January 2015. There was documentation by the Resident Family Services Co-ordinator related to the conference; however, there was no input from the nursing, restorative care, recreation or dietary departments related to their review of the resident's plan of care. It was unclear who attended the conference. [s. 27. (1) (c)]

WN #9: 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 has failed to ensure that all staff participated in the home's infection prevention and control program related to labelling of personal care items.

On on an identified date in February 2015, Inspector #169 observed unlabelled used hair brushes with hair in them in the tub and shower rooms throughout the home. The DOC confirmed that all personal items should be labelled. [s. 229. (4)]

Issued on this 24th day of March, 2015

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

Original report signed by the inspector.