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**

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| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Nov 3, 2017 | 2017_556168_0031 | 023352-17 | 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

LISA VINK (168), DIANNE BARSEVICH (581), JESSICA PALADINO (586)

## 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): October 11, 12, 13, 16, 17, 18 and 19, 2017.**

**During the course of this inspection the following additional intakes were completed:**
**Inquiries**
**013798-17 - related to powers of family council**
**021173-17 - related to powers of family council**
**Complaints**
**033376-16 - related to plan of care, transferring and positioning techniques, Residents' Bill of Rights, dealing with complaints, personal care and food services workers**
**024519-17 - related to plan of care, infection prevention and control, duty to protect and falls prevention and management**
**Critical Incident**
**001746-17 - related to duty to protect and falls prevention and management.**

**During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), co-directors of care (co-DOC), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), dietary staff, recreation staff, staff educator, nutrition manager (NM), family members and residents.**

**During the course of the inspection, the inspectors toured the home, observed the provision of care and services, reviewed relevant records including but not limited to: meeting minutes, policies and procedures, incident reports and clinical health records.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Housekeeping**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**
**Skin and Wound Care**

**During the course of this inspection, Non-Compliances were issued.**
- **6 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (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 failed to ensure that the written plan of care for each resident set out the planned care for the resident.

Resident #004 had known responsive behaviours according to interviews with RN #102 and PSW #103.
A review of the clinical record, for the past year, included progress notes related to identified responsive behaviours dating back to March 2016, similar behaviours demonstrated in July 2017, and a second behaviour identified in August 2017, for which staff monitored the resident into September 2017.
A review of the plan of care did not include the behaviours identified during staff interviews or in the progress notes, nor the interventions of staff as confirmed by RN #102.

The RN verified that the plan of care should have contained the behaviours that the resident displayed and the interventions of staff as these were needs and planned care of the resident. [s. 6. (1) (a)]

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

In September 2017, resident #012 was identified with an injury. A diagnostic test was ordered and the results were faxed to the home seven days later.
i. The resident's SDM identified that they were not notified about the results of the test until they inquired about it four days after the test results were faxed to the home.
In an interview with the DOC on October 18, 2017, it was confirmed that there was no documentation to demonstrate that the SDM was notified when the test results were received.
The Administrator acknowledged that they did not notify the SDM until four days later.
ii. The home completed an internal investigation to determine the cause of the injury, including multiple staff interviews which were completed the day after the injury was noted.
The Administrator told the SDM that the co-DOC would follow up with them regarding the details of the investigation, as per documentation, ten days later.
The SDM was not given the results of the investigation until 11 days later. [s. 6. (5)]

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

A. Review of the plan of care for resident #011 identified they had a condition.
The progress notes included specific directions from the physician on how to manage the condition.
In 2017, registered staff #116 documented in the progress notes that they provided care related to the condition, not as directed by the physician.
Interview with co-DOC #117 stated that the condition was to be managed as specified by the physician and confirmed that the care set out in the plan was not provided to the resident.
B. The SDM of resident #005 reported that the resident's plan of care was not being followed in the dining room related to the fluids they received.
Resident #005's plan of care indicated the following, "as per family, serve only a specific

item at breakfast only and do not serve at any other meal".
During the lunch meal on October 13, 2017, the resident was observed being fed the specific item.
The resident was not provided care as specified in their plan of care.
C. A review of the clinical record identified that resident #011 had a device in their room to store a specific treatment to be utilized under a specific situation.
The electronic Medication Administration Record (eMAR) for an identified month in 2014, indicated that the device was to be checked on the 15th of the month to ensure the treatment was appropriate and was to be available for use if the resident had a change in their condition.
Review of the plan of care on September 20, 2017, identified that the resident had a change in condition and the treatment was started; however, there was no treatment available in the resident`s room and the registered staff took the treatment from another location.
Interview and review of the clinical record with the DOC stated that the treatment was to be in the resident`s room and confirmed that the care set out in the plan of care was not provided. [s. 6. (7)]

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

A. In December 2017, the progress notes for resident #011 identified that they were assessed to have a condition, the physician was notified and gave specific direction on how to manage the condition.
Review of the written plan of care identified seven days later that staff were to monitor the resident for the condition and manage it as needed.
Interview with the co-DOC identified that the resident had the condition and confirmed the plan of care was not reviewed and revised when the resident's care needs changed until seven days after the diagnosis.
B. The plan of care for resident #006 identified that they had altered skin integrity and included goals that the resident's "wounds will heal" and to "attain intact skin integrity".
A review of the clinical record and interviews with RN #108, PSWs #106 and #107, each confirmed that the resident's skin was currently intact.
RN #108 reviewed the plan of care and confirmed that it was not reviewed or revised with changes in the resident's care needs and when care was no longer necessary. [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 the planned care for the resident, 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 the opportunity to participate fully in the development and implementation of the resident's plan of care, to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, and to ensure that the resident is reassessed and the plan of care is reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

**Specifically failed to comply with the following:**

**s. 50. (2) Every licensee of a long-term care home shall ensure that,**
**(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,**
**(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,**
**(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,**
**(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and**
**(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Resident #006 had a history of altered skin integrity which would open, resolve and open again according to the clinical record and RN #117.
According to a progress note the area reopened in July 2017.
A review of the progress notes and assessment in Point Click Care (PCC) did not include that the area was assessed using a clinically appropriate assessment instrument that was specially designed for skin and wound assessment.
Interview with RN #117, following a review of the clinical record verified that an assessment of the area was not completed using a clinically appropriate assessment instrument until 30 days after it had been identified. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Interviews with RNs #102, #108 and #117 each identified that residents with altered skin integrity were to have a reassessment of the area at least weekly.
i. A review of the clinical record identified that resident #006 had a history of altered skin integrity in a specified area.
This area was identified by RN #117 with a history of open, resolve and then reopen again.
According to the clinical record the area reopened in July 2017.
The next reassessment of the area, by a member of the registered nursing staff, was completed 30 days later in August 2017.
The area was not reassessed at least weekly as confirmed by RN #117, following a review of the clinical record. [s. 50. (2) (b) (iv)]

***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 who exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council**

**Specifically failed to comply with the following:**

**s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that they responded in writing within 10 days of receipt of Family Council advice related to concerns or recommendations.

A. Review of the April 6, 2016, Family Gathering Meeting Minutes included a suggestion for blinds to be installed in the family dining room. This concern was responded to by the Administrator, who was at the home, at the time of the meeting, which identified that they would look into options for the room.
There was no additional documentation available to indicate that further information was provided to the family members by the former Administrator.
A review of the October 5, 2016, Family Gathering Meeting Minutes included a request for drapes in the family dining room as discussed at the April 2016, meeting; however, no response was provided to the request, as confirmed by the Administrator that they were not provided with a copy of the Meeting Minutes.
Review of the April 5, 2017, Family Gathering Meeting Minutes included a question regarding plans to frost the glass in the dining rooms.
The current Administrator's written response to the question identified that there were

currently no plans to frost the dining room windows. Interview with the Administrator identified that she thought that the request was to frost the resident dining room windows and not the family dining room as previously requested at Family Gathering Meetings. She identified that she was unaware of this previous request and that she did not seek clarification regarding the question prior to providing the response.
B. Review of the June 9, 2016, Family Gathering Meeting Minutes included a question related to fire procedure, as well as a request to speak with the fire inspector.
A review of the June 13, 2017, written responses provided did not include responses to the two issues identified above, which was confirmed by the Administrator following a review of the Meeting Minutes and responses.
C. Review of the October 5, 2016, Family Gathering Meetings Minutes included questions or comments regarding the use of umbrellas, drapes for the family dining room, a new phone system and staff wearing name tags.
There were no responses provided to the questions or comments identified at the meeting as confirmed by the Administrator following a review of the Meeting Minutes as she had not previously received the minutes.
D. Review of the May 3, 2017, Family Gathering Meeting Minutes included questions related to the distribution of meals and snacks under specific situations.
A review of the May 3, 2017, written response to the meeting did not include any response to these two questions, which was confirmed by the Administrator following a review of the Meeting Minutes and responses.
E. Review of the June 7, 2017, Family Gathering Meeting Minutes included a suggestion related programming.
A review of the June 7, 2017, written response to the meeting did not include a response to the suggestion, which was confirmed by the Administrator following a review of the Meeting Minutes and responses. [s. 60. (2)]

***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 licensee responds in writing within 10 days of receipt of Family Council advice related to concerns or recommendations, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production**

**Specifically failed to comply with the following:**

**s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,**
**(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).**

**Findings/Faits saillants :**

1. The license failed to ensure that all food and fluids in the food production system were prepared, stored and served using methods to preserve taste, nutritive value, appearance, and food quality.

Resident #012's documented plan of care indicated that they required a pureed diet. The resident received pureed squash and Italian vegetables at dinner on October 17, 2017, which were very thick, gelatinized, and clear in colour, appearing like dessert. The resident's SDM tasted the vegetables and indicated that they lacked flavour. The NM observed the pureed items and confirmed that they were not appropriately prepared by dietary staff #119, as too much thickener was added, thus compromising the taste, nutritive value, appearance, and food quality. [s. 72. (3) (a)]

***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 all food and fluids in the food production system are prepared, stored and served using methods to preserve taste, nutritive value, appearance, and food quality, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions**

**Specifically failed to comply with the following:**

**s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,**
**(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).**
**(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).**

**s. 135. (3) Every licensee shall ensure that,**
**(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).**
**(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).**
**(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that every medication incident which involved a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

On request the home provided the Medication Incident Forms for April, May and June 2017.
A review of the Incident Forms identified medication incidents were not consistently documented as required, documentation was not consistently available to support that immediate actions were taken to assess and maintain the resident's health nor were all required parties notified.

A. Resident #013 was involved in a medication incident in April 2017, which was discovered and reported, by a member of the nursing management staff, four days later, according to the Incident Form.
A review of the Incident Form and the clinical record identified that there was no record of immediate actions taken to assess and maintain the resident's health, or that the incident was reported to the resident, the resident's SDM, if any, the Medical Director or the prescriber of the drug, as confirmed by the DOC following a review of the Incident Form and progress notes.
B. Resident #015 was involved in a medication incident in May 2017, which was discovered and reported, by another registered staff member approximately two months later, according to the Incident Form.
A review of the Incident Form and the clinical record identified that there was no record of immediate actions taken to assess and maintain the resident's health, or that the incident was reported to the resident, the resident's SDM, if any, the Medical Director, the prescriber of the drug or the pharmacy service provider, as confirmed by the DOC following a review of the Incident Form and progress notes. [s. 135. (1)]

2. The licensee failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, that any changes and improvements identified in the review were implemented, and a written record was kept of everything as required.

The home provided the Medication Incident Forms for April, May and June 2017, on request, as well as their quarterly review of all medication incidents and adverse drug reactions for the same time period.
Interview with the DOC identified that the home completed the quarterly review of the identified incidents during the Professional Advisory Committee (PAC) which was held on July 27, 2017.
A review of the PAC meeting minutes for July 27, 2017, identified that the home had only one medication incident in April 2017 and that this was the only incident included for review for April 2017.
A review of the Incident Forms revealed three forms dated for April 2017, each for different incidents.
Interview with the DOC identified that the two additional Incident Forms must have been provided to her some time after the Monthly Medication Incident Analysis and PAC meeting was completed.
The DOC confirmed awareness of the incidents, although was not working at the home

when they occurred; however, was not able to explain why the incidents were not included as part of the quarterly review as required. [s. 135. (3)]

***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 every medication incident which involved a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.***

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**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 failed to ensure that the equipment was maintained in a safe condition and in a good stated of repair.

Review of the plan of care identified that in 2017, a bed alarm was applied to resident #011's mattress to alert staff when the resident was getting out of bed.
In the same month, eight days later, the resident fell from their bed and sustained injuries.
Review of the post falls assessment identified that the bed alarm did not activate when the resident was getting out of their bed.
Interview with RPN #121 stated that they assessed the resident post fall and confirmed that the bed alarm did not activate and was not in a good state of repair. [s. 15. (2) (c)]

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**Issued on this 3rd day of November, 2017**

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

**Original report signed by the inspector.**