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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 8, 2019	2018_570528_0008	030523-16, 032131-16	Critical Incident System

Licensee/Titulaire de permis

Waterdown Long Term Care Centre Inc.
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

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

CYNTHIA DITOMASSO (528), MICHELLE WARRENER (107)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 21, 22, 23, 26, 27, 28, 28, 30, December 3, 4, 5, 6, 10, 2018

This Critical Incident Inspection included the following:
i. Critical Incident System Log #030523-16 and 032131-16 related to responsive behaviours

This inspection was completed concurrently with Complaint Inspection #2018_570528_0007

Non-compliance related to LTCHA s. 6(10) identified during this inspection, was included in Complaint Inspection report # 2018_570-528_0007 and issued as a voluntary plan of correction (VPC).

During the course of the inspection, the inspector(s) spoke with the Administrator, the Directors of Care (DOCs), the Nutrition Manager, Staffing Coordinator, Housekeeping/Laundry Manager, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), dietary aides, residents and families.

During the course of the inspection, the inspector(s) observed the provision of care and services, reviewed documents including but not limited to, medical records, staffing schedules, policies and procedures, complaints logs, meeting minutes, investigation notes, and staff files

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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	Légende 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. 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 failed to ensure that residents were protected from abuse by anyone.

Critical Incident #2861-000020-16, log # 030523-16, submitted in October 2016, described an altercation between resident #012 and #013 causing injury to resident #013.

For the purposes of the Long-Terms Care Homes Act, 2007 and Ontario Regulation 79/10, resident to resident physical abuse is defined as the use of force by a resident that causes physical injury to another resident.

Review of the plan of care for resident #012 identified that they had multiple diagnosis history of responsive behaviours. Review of the Critical Incident System (CIS) report, identified that in October 2016, resident #012 and #013 were in an altercation, causing distress and injury to resident #013. Interview with the DOC, confirmed that as a result of the incident in October 2016, resident #013 was harmed following the altercation. (528)

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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #2: 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. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with by staff.

The home's policy, 'Abuse – Zero Tolerance Policy for Resident Abuse and Neglect – Zero Tolerance Policy for Resident Abuse and Neglect', revised June 2017, required Personal Support Workers (PSW) to report any allegations of abuse to the Charge Nurse and the Charge Nurse was required to contact management immediately.

During interview with the Administrator (#101), they confirmed the information in the policy at the time of the incident stated that if abuse was reported by a resident, PSW staff were required to report to the charge nurse who then was required to call management staff immediately.

Documentation in resident #011's progress notes from 2016 identified that the resident reported to staff that they were in an altercation with a coresident and it was documented in the resident's record by the Registered Nurse (RN). The Director was informed of the alleged abuse the following day, through the after hours pager.

During the course of the inspection, the Director of Care (#102) stated that the registered staff member did not report to management immediately and that the incident was reported to the Director the next day when management staff became aware of the alleged abuse. The DOC stated the registered staff member was re-educated on the home's prevention of abuse and neglect policy.

The licensee did not comply with the home's policy for prevention of abuse and neglect.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions.

Resident #010 was exhibiting responsive behaviours between October 2016 and February 2017.

Documentation in resident #010's progress notes identified several incidents of responsive behavious which distressed coresidents.

In November 2016, an intervention was initiated for the resident for a period of time. Staffing schedules provided by the Staffing Coordinator (#107) and Director of Care (#102) identified that the intervention was not consistently implemented during the identified time frame.

Staffing schedules and confirmation by the Staffing Coordinator (#102) confirmed that the intervention was not implemented when several incidents occurred where the resident was involved in altercations with and displaying responsive behaviours towards coresidents.

Complaints received by the home in the identified time period, expressed concerns related to the behaviours of resident #010. The home responded to the complainant; however, when the issue was noted to be resolved, the resident was still exhibiting the same behaviours and interventions were not not consistently being provided.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions. [s. 54. (b)]

Issued on this 12th day of February, 2019

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

Original report signed by the inspector.