Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
Jul 8, 2019	2019_549107_0008	002394-17, 006586-17, 015865-17, 022750-17, 027810-17, 002040-18, 018152-18	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

MICHELLE WARRENER (107), YVONNE WALTON (169)

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): May 23, 24, 27, 28, 29, 30, 31, June 4, 5, 6, 7, 2019.

The following intakes were completed in this Critical Incident System Inspection:
Log #002394-17, CIS #SAC14590/2861-000003-17, related to resident to resident altercation,
Log #022750-17, CIS #16905/2861-000019-17, related to resident to resident altercation,
Log #018152-18, CIS #2861-000007-18, related to fall with injury,
Log #002040-18, CIS #18359/2861-000002-18, related to unexpected situation,
Log #006586-17, CIS #2861-000010-17, related to fall with injury,
Log #015865-17, CIS #2861-000015-17, related to fall with injury,
Log #027810-17, CIS #SAC 17702/2861-000025-17, related to resident to resident altercation.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care, Co-Directors of Care, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitian (RD), Physiotherapist (PT), Medical Director, Physician, Pharmacist, and Laboratory Manager of Customer Service of Long Term Care.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **0 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 staff and others involved in the different aspects of care of resident #008 collaborated with each other in the assessment of the resident and in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

A. Resident #008 was assessed by a consultant on a specified date. The consultant provided a list of recommendations and directions for staff to follow. Inspector #107 reviewed the resident's clinical health record and the information recommended by the consultant had not been integrated into the resident's written care plan (the document that staff used to provide direction related to care for the resident).

During interview with Inspector #107, the Registered Dietitian stated that they had updated part of the care plan, however, stated that other sections of the resident's care plan were to be updated by Registered Nursing staff.

During interview with Inspector #107, Registered Nurse (#108) stated that the Registered Dietitian would update the resident's care plan.

During interview with Inspector #107, the Director of Care (#103) confirmed that the resident's written care plan did not include the recommendations from the consultant.

Staff did not collaborate in the development and implementation of resident #008's plan of care to ensure that strategies recommended by the consultant were integrated into the resident's plan of care.

B. Staff did not collaborate with each other in the assessment of resident #008 related to the level of assistance required for eating, and in the integration of those strategies on the resident's plan of care.

Documentation in resident #008's progress notes identified the resident required increased assistance from staff at meals. The requirement for increased assistance had not been included in the resident's written plan of care.

During interview with Inspector #107, Registered Dietitian #107 confirmed that staff had not communicated to the Registered Dietitian the change in the level of assistance the resident required for eating and documentation in the resident's clinical health record did not include a referral to the Dietitian for assessment of the change in assistance level. The Registered Dietitian stated that if the resident required increased assistance with eating, the information should have been communicated to the Registered Dietitian and should have been included in the resident's written plan of care. [s. 6. (4)]

2. The licensee did not ensure that resident #008 was given an opportunity to participate fully in the development and implementation of their plan of care.

Resident #008 was admitted to the long-term care home on a specified date. Assessments prior to admission indicated that the resident was involved in decisions about their care. During interview with the resident's Physician (#109), they stated that the resident was capable of making decisions about their care and that the resident's

Substitute Decision Maker (SDM) was not involved in the decision-making process prior to admission to the LTC home.

During interview with Inspector #107, Registered Dietitian (#107) indicated that they documented in the progress notes who was spoken to during the assessment process. Documentation in the resident's progress notes, written by the Registered Dietitian, identified the Dietitian spoke with the resident's Substitute Decision Maker (SDM) and staff during the assessment process. The Registered Dietitian indicated they revised the resident's plan of care to include nutritional interventions and the changes were discussed with the resident's SDM. Rationale for not including the resident in the discussions was not identified in the documentation. During interview with Inspector #107, the Registered Dietitian could not recall if the resident was included in the assessment and care planning process.

Progress notes written by Registered Nurse (RN) #108 on two identified dates, stated that the resident's SDM was called for consent for treatments and for vaccine administration. During interview with Inspector #107, RN #108 confirmed the resident was capable for decisions about their care. The RN stated that it was the home's practice to have the resident's SDM sign all the admission paperwork, including consent documents and Advance Directives. The RN confirmed that residents were not consistently included in the process for obtaining consent for treatment upon admission to the long-term care home. [s. 6. (5)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to resident #008 as specified in the plan related to admission Physician orders.

Resident #008 was admitted to the home on a specified date. The resident had a specific diagnosis and was taking a medication that required monitoring.

The home's "Admission Order Form" was completed on the day of admission and ordered by the admitting Physician (#105).

The Director of Care (#103) and Registered Nurse (#108) identified the home's procedure for obtaining admission orders. The procedure was not followed for the admission orders and the resident's admission order was not completed for 13 days.

During interview with Inspector #107, a consultant confirmed that the admission order was not completed until 13 days after it was ordered by the Physician.

During interview with Inspector #107, the admitting Physician (#105) and the Pharmacist (#110) both stated that their decision making related to the dosage of medication was based on the assumption that the resident would have their admission orders completed within one week after admission to the long-term care home. The Physician (#105) and Pharmacist (#110) confirmed that the admission orders should have been completed prior to 13 days after admission to the long-term care home.

The plan of care related to admission orders was not followed for resident #008 as specified in their plan. [s. 6. (7)]

4. The licensee failed to ensure that the care set out in the plan of care for resident #007 was provided to the resident as specified in the plan related to responsive behaviours.

Resident #007 had a plan of care that directed staff to implement specific strategies related to responsive behaviours. The plan was initiated prior to two incidents.

On a specified date, resident #007 exhibited the identified responsive behaviours towards a co-resident.

On a second specified date, resident #007 exhibited the same responsive behaviours towards a co-resident. During interview with Inspector #107, Co-DOC (#112) confirmed that the strategies identified in resident #007's plan of care were not followed by staff related to the responsive behaviour incident.

The plan of care related to the responsive behaviours of resident #007 was not followed by staff, resulting in resident #007 exhibiting responsive behaviours towards two residents. [s. 6. (7)]

5. The licensee did not ensure that resident #008 was reassessed and the plan of care reviewed and revised when the resident's care needs changed in relation to the resident's clinical health status.

A. Resident #008 was admitted to the long-term care home on a specified date. The resident had a decline in condition, however, neither the resident's Physician (#109) or Medical Director (#105) were contacted to inform them of the change in condition.

During interview with Inspectors #107 and #169, the resident's Physician (#109)

confirmed they had not been notified of the resident's change in condition. Some of the changes in condition were written in the Physician communication book, however, the Physician had not received the notification in the communication book. During interview with Inspector #107, Physician #109 stated that they should have been notified of the change in condition of the resident.

B. The resident's Physician (#109) was also not informed when the resident had a change in condition and required a specific treatment. The Medical Director, (#105), who was not the resident's most responsible Physician, was called about the resident's change in condition and they ordered a medication. The resident's Physician (#109) stated during interview, that they had not been informed of the change in condition or treatment the resident received. [s. 6. (10) (b)]

6. The licensee failed to ensure that residents #005 and #006 were reassessed and their plan of care reviewed and revised when the care set out in the care had not been effective in relation to responsive behaviours.

Critical incident #2861-000025-17 was submitted to the Ministry of Health and Long-Term Care (MOHLTC), identifying that resident #005 had an un-witnessed altercation with resident #006 that resulted in injury to resident #006.

Resident #005 had a history of responsive behaviours. The resident's plan of care prior to the incident identified behavioural triggers.

During interview with Inspector #107, Registered Practical Nurse (RPN) #113 also identified triggers for resident #005's responsive behaviours and noted the behaviours of resident #006 disturbed resident #005.

Documentation on Critical Incident report 2861-000025-17, related to the incident, demonstrated a history of responsive behaviours from resident #005. The CIS report also identified that LTC staff were aware that resident #006 also had responsive behaviours that resulted in altercations almost daily.

During interview with Inspector #107, Registered Nurse (RN) #108 stated that there were altercations between resident #005 and resident #006 routinely.

Strategies on the plan of care to address the responsive behaviours of both residents #005 and #006 were not revised until after the altercation that caused injury to resident

#006. [s. 6. (10) (c)]

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 where the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O.Reg. 79/10, s. 114(2) the licensee was required to have written policies and protocols that were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Specifically, staff did not comply with the licensee's policy, "Resident Rights, Care and Services – Medication Management – Administration of Medications".

The policy directed staff to evaluate the appropriateness of the prescribed medication for the resident and to discuss any concerns with the prescriber prior to administration of the medication. The policy also directed staff to communicate any concerns to the prescriber and document the same in the multidisciplinary record.

Documentation in resident #008's clinical health record did not include an evaluation of the appropriateness of the medication or any documented concerns with the prescriber prior to the administration of the medication and as per the electronic Medication Administration Record (eMAR), the medication was administered to the resident over a twelve day period by a number of different registered staff.

During interview with Inspector #107, Registered Nurse #108, who completed the admission process for resident #008, stated that they had questioned the Physician about the dosage of medication being ordered for resident #008, however, they confirmed they had not documented the concerns or conversation with the resident's Physician. [s. 8. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that resident #003 was positioned safely while being assisted. A critical incident was submitted to the Ministry of Health and Long-Term Care (MOHLTC), #2861-000015-17, and identified the resident had a fall that resulted in injury.

The initial plan of care for the resident was developed and identified specific risks related to positioning. On a specified date, the resident was assisted with positioning by staff #106. The resident fell resulting in injury to the resident. The staff member did not use a safe technique to assist resident #003.

Interview with staff #106 confirmed the resident had a fall and they did not use a safe technique to assist the resident. Interview with DOC #103 confirmed the staff did not use a safe technique to assist the resident. [s. 36.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 82. Attending physician or RN (EC)

Specifically failed to comply with the following:

s. 82. (1) Every licensee of a long-term care home shall ensure that either a physician or a registered nurse in the extended class,
(a) conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination; O. Reg. 79/10, s. 82 (1).
(b) attends regularly at the home to provide services, including assessments; and O. Reg. 79/10, s. 82 (1).
(c) participates in the provision of after-hours coverage and on-call coverage. O. Reg. 79/10, s. 82 (1).

Findings/Faits saillants :

1. The licensee did not ensure that either a physician or a registered nurse in the extended class, conducted a physical examination of resident #008 upon admission with a written report of the findings of the examination.

Resident #008 was admitted to the home on a specified date. Inspector #107 reviewed the resident's clinical health record and an admission physical assessment was not included in the resident's record.

Physician #109 confirmed that they completed a preliminary assessment of the resident, however, they did not complete an admission physical for resident #008. During interview with Inspector #107, the Medical Director (#105) could not recall if they had completed an admission physical for resident #008.

The Director of Care (#103) reviewed the clinical health record and also confirmed a written report of the admission physical examination was not available. [s. 82. (1) (a)]

Issued on this 8th day of July, 2019

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

Original report signed by the inspector.