Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jun 1, 2021	2021_555506_0014	018629-20, 025110-20, 005266-21, 007690-21	Critical Incident System

Licensee/Titulaire de permis

Waterdown Long Term Care Centre Inc.
c/o Jarlette Health Services 711 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

LESLEY EDWARDS (506)

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 6, 7, 10, 12, 13, 14, 17, 19, 20, 25 and 26, 2021.

This inspection was completed concurrently with Complaint Inspection 2021_555506_0013.

This inspection was completed related to the following intakes:

018629-20- for Critical Incident System (CIS) 2861-000010-20 for prevention of abuse and neglect ;
025110-20- for CIS 2861-000019-20 for falls prevention and management;
005266-21- for CIS 2861-000004-21 for falls prevention and management; and
007690-21- for CIS 2861-000008-21 for falls prevention and management.

Findings of non-compliance related to Ontario Regulation (O. Reg.) 79/10, s. 8 (1) b related to policies, etc. to be followed and s. 30 (2) related to general requirements were identified in this inspection and have been issued in Complaint Inspection Report 2021_555506_0013, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Co-Director of Cares, Nurse Managers, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), housekeeping staff, restorative care co-ordinator, families and residents.

During the course of the inspection, the inspector completed an IPAC checklist, observed resident care, meal and snack service, medication pass, reviewed resident health records, conducted interviews and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation

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	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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was provided to resident #006 and resident #008 as specified in the plan.

i. A CIS was submitted to the Director in March 2021, regarding resident #006 sustaining an injury.

A review of the written plan of care for resident #006 identified that they were assigned an intervention to be in place at all times.

On an identified date in March 2021, resident #006's intervention was not in place and the resident sustained an injury.

The DOC confirmed that the expectation of the intervention was that it was to be in place at all times and the resident's plan of care was not followed.

Sources: CIS, review of resident's clinical record and staff interviews.

ii. A CIS was submitted to the Director in September 2020, regarding resident #008.

A review of the written plan of care for resident #008 identified that they were to have an intervention in place at all times.

On an identified date in September 2020, resident #008 did not have have their intervention in place and this was confirmed with the DOC.

The risk with not having the intervention as per resident #008’s plan was that they were not being monitored at all times and the incident may have not occurred.

Sources: CIS, resident's clinical record and staff interviews. [s. 6. (7)]

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 plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 resident #009 was protected from abuse by resident #008.

A CIS was submitted to the Director for an incident of abuse towards resident #009 from resident #008 on an identified date.

A review of clinical records confirmed that PSW #124 entered the doorway of the lounge, they observed resident #008 abusing resident #009.

A review of resident #008's plan of care identified that an intervention was not in place on the identified date.

As a result of not having the intervention in place for resident #008, resident #009 was not protected from abuse.

Sources: CIS , resident #008 and #009's clinical records and staff interviews. [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 that residents are protected from abuse by anyone, to be implemented voluntarily.

Issued on this 9th day of June, 2021

[redacted]

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

Original report signed by the inspector.