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_0013	017978-20, 006272-21, 006275-21, 007450-21, 007576-21	Complaint

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 Complaint 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 Critical Incident Inspection 2021_555506_0014.

This inspection was completed related to the following intakes:

017978-20- related to personal support services;
006272-21- related to abuse and neglect;
006275-21- related to abuse and neglect;
007450-21- related to restraints; and
007576-21- related to restraints.

Findings of non-compliance related to Ontario Regulation (O. Reg.) 79/10, s. 8 (1) b related to policies, etc. to be followed, 30. (2) related to general requirements were identified in a concurrent Critical Incident Inspection, Inspection Report 2021_555506_0014, and were issued in this report.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Co-Directors of Care (Co-DOC), Nurse Managers, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), housekeeping staff, Environmental Service Manager, restorative care co-ordinator, Physician's, Physiotherapist, Hamilton Police, families and residents.

During the course of the inspection, the inspector toured the home, observed the provision of care, reviewed clinical records, complaints and concern forms, investigation notes, conducted interviews and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

- **2 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 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 where the Act and 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 S. O. 2007, s. 8 (1), and in reference to O. Reg. 79/10, s. 30 (2), the licensee is required to have written policies developed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Specifically, registered staff did not comply with the licensee's policy titled: "Resident Rights, Care and Services- Plan of Care policy and procedure", which directed staff to document assessments, care, services and risk completed as close to the time of the occurrence as possible and within the scheduled shift.

A. Resident #010 had developed an injury on an identified date in April 2021, and was diagnosed with medical condition in the same area five days later. A review of the clinical record identified that registered staff did not document care, services or assessments as indicated as close to the time of occurrence as possible and within the scheduled shift.

i. Assessments, care and services were documented by RPN #136, which was 14 and 15 days after the injury to the identified area in resident #010's clinical record.
ii. Assessments, care and services were documented by RPN #123, one day after the SDM alerted staff of the change in condition and subsequent diagnosis of the medical

condition.

B. Resident #007 sustained a fall on an identified date in December 2020, and was assessed with no injuries. Resident #007's substitute decision maker (SDM) had concerns that the resident was experiencing some health concerns. Resident #007 was subsequently transferred to hospital for further medical intervention A review of the clinical record identified that the registered staff did not document care, services or assessments as indicated as close to the time of occurrence as possible and within the scheduled shift.

i. Assessments, care and services that were completed by RPN #137 post fall on identified dates in December, 2020, were documented, seven and eight days later.
ii. Assessments, conversations with the SDM and notes left for the physician completed by RPN #120 post fall on an identified date in December 2020, were documented, seven days later.
iii. Assessments, care and conversations with the SDM completed by RPN #135 post fall on an identified date in December 2020; were documented, the following day.

C. Resident #011 was found on an identified date in May 2021, with a specified item wrapped around a part of their body and was assessed with no injuries. A review of the clinical record identified that the registered staff did not document care, services, risk or assessments as indicated as close to the time of occurrence as possible and within the scheduled shift.

i. Assessments, care, services and risk were completed by Co-DOC #102 after the incident; however, these assessments and conversations with the SDM were not documented in resident #011's clinical record until 14 days later.

The DOC confirmed that the licensee's policy was not followed as the registered staff did not complete their documentation regarding their assessments, care, services and risk for residents #010, #007 and #011 in a timely manner and within their scheduled shifts.

The risk of not completing timely documentation of the resident assessments care and services does not allow the multidisciplinary team to compare assessments, identify changes in the residents and revise the plan of care.

Sources: clinical records for residents #010, #007 and #011, interview staff and the home's policy "Resident Rights, Care and Services- Plan of Care" (dated September

2019). [s. 8. (1) (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 where the Act and Regulation required the licensee of a long term care home to have, institute or otherwise put in place any policy, the policy is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 35. Prohibited devices that limit movement
Every licensee of a long-term care home shall ensure that no device provided for in the regulations is used on a resident,
(a) to restrain the resident; or
(b) to assist a resident with a routine activity of living, if the device would have the effect of limiting or inhibiting the resident's freedom of movement. 2007, c. 8, s. 35.

Findings/Faits saillants :

1. The licensee has failed to ensure that no device provided for in the regulation was used on a resident to restrain a resident.

In reference to Ontario Regulation 79/10, s. 112 (7), the following devices are prohibited for use in the home that limit movement: sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose.

On an identified date in May 2021, at approximately 0805 hours, PSW #131 discovered resident #011 with a body part wrapped in a specified item. The PSW called RPN #120 to come and assess the resident. The RPN then took a picture of the resident and went to report the incident to the Co-DOC #102.

The Co-DOC #102 and RPN at this time proceeded to remove the item from the resident’s body with great difficulty.

The Co-DOC sent an email to the Administrator and DOC that morning and stated to them that the resident was strategically tied up. At the time of this inspection the home and the police were still conducting their investigation into the incident.

An interview with the Administrator confirmed that the specified item is considered a prohibited device and is not to be used on a resident.

Sources: clinical record review, observation of the resident, interview with staff and investigation notes. [s. 35. (a)]

Issued on this 9th day of June, 2021

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

Original report signed by the inspector.