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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 26, 2013	2013_188168_0020	H-000251-13	Complaint

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)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 14, 15 and 20, 2013 (onsite) and August 21 and 26, 2013 (telephone interviews conducted).

This inspection report is related to inspections H-000251-13, H-000446-13 and H-000447-13.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, the Director of Nursing Care (DOC), registered nursing staff, unregulated staff and residents.

During the course of the inspection, the inspector(s) observed the provision of care and services to identified residents, reviewed documents including but not limited to: policies and procedures and plans of care, and toured the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

Accommodation Services - Laundry

Dignity, Choice and Privacy

Falls Prevention

Medication

Pain

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 did not ensure all procedures instituted or otherwise put in place were complied with.

The procedure "Medication Management System - Administration of Medications, last revised June 2009" directed staff, following the administration of medications to ensure that appropriate monitoring and interventions were implemented as required.
A. It was observed during the noon medication pass on August 14, 2013, that medications were provided to resident #005 in the dining room, while seated at the table with another resident. The nurse who gave the medication did not remain with the resident to ensure that they were consumed and left the dining room to continue to dispense medications. The resident, who did consume the medications, did not have an order to "self administer medications".
B. It was observed during the noon medication pass on August 15, 2013, that medications were provided to resident #006 in the dining room. The nurse did not remain with the resident to monitor that the medications had been consumed. The resident did not have an order to "self administer medications".
C. Progress notes reviewed for resident #003 identified a number of entries from October 22, 2012, until May 31, 2013, identifying that medications were found at the resident's beside or that staff "checked back" to ensure that medications were consumed as provided. On March 12, 2013, a "Concern/Compliments" form was initiated due to concerns with the resident not taking medications as prepared by nursing staff.

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 procedures instituted or otherwise put in place are complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the pain management program was consistently implemented in the home.

The "Pain Management Program, last revised July 2013" identified that every resident would receive prompt pain management interventions according to assessment and the resident's wishes and that every resident would be screened for pain with changes in condition, through the use of the "pain screening" notes in point click care.
A) Resident #004 sustained a fall in 2013, which resulted in injury. According to the progress notes and Medication Administration Records (MAR), the resident demonstrated pain, at the site of injury, on three occasions immediately following the fall. The resident was not provided with pain management interventions, pharmacological or non-pharmacological, during this period of time. The injury was further assessed and diagnosed as a fracture a few days later, at which time pharmacological and non-pharmacological interventions were prescribed.
B) The plan of care for resident #004 identified the need to be assessed for pain every day and evening shift post fall. Staff consistently initialed the completion of this assessment on the Treatment Administration Record (TAR). Interview with registered staff and the DOC confirmed that this intervention on the TAR required staff to complete a "pain screening" note in point click care regarding assessment findings. For a 27 day period, progress notes were not completed, as required, regarding the resident's pain, on 20 occasions, and no notes titled "pain screening" were completed. The resident had a decrease in prescribed narcotic analgesic on a specific day, with no notes regarding pain management recorded for that day, the following evening shift, or the day shift two days later. The dosage of narcotics was decreased a second time, with no notes regarding pain management completed for the evening shift the day of the change, or the following day.

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 pain management program is fully implemented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure at each resident had his or her personal health information (within the meaning of the Personal Health Information Protection Act, 2004) kept confidential.

Not all residents had their personal health information (PHI) kept confidential in the home.
A. On August 14, 2013, PHI of residents was not kept confidential in the following locations:
i) In home area two, during the noon medication pass, staff left the medication cart unattended in the hallway outside of a resident's room. The computer display screen on the cart was unlocked and displayed the MAR of an identified resident.
ii) In home area three, the computers in the nurses station were unlocked and unattended while the residents were being served lunch in the dining room. Both screens were open and displayed portions of resident's clinical records, which contained PHI.
iii) In home area one, during the noon meal, papers were positioned on the desk at the nurses station which made them easily accessed and reviewed by individuals standing on the opposite side of the desk. These papers included: lab reports as well as a Behaviour Supports Ontario (BSO) discharge note of a resident.
B. On August 15, 2013, PHI of residents was not kept confidential in the following locations:
i) In home area two, at approximately 0915 hours, papers were positioned at the desk in the nurses station which made them easily accessed and reviewed by individuals standing on the opposite side of the desk. These papers included: a consult note for a specified resident from St. Peters and a x-ray report for another resident.
ii) In home area three, at approximately 0910 hours, papers were positioned at the desk in the nurses station which made them easily accessed and reviewed by individuals standing on the opposite side of the desk. These papers included: a ultrasound requisition which identified the resident's name and the procedure to be completed.
iii) In home area one, at approximately 0930 hours, papers were positioned at the desk in the nurses station which made them easily accessed and reviewed by individuals standing on the opposite side of the desk. These papers included: the same BSO discharge note which was accessible on August 14, 2013. [s. 3. (1) 11. iv.]

Issued on this 26th day of August, 2013

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