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

Division de la responsabilisation et de la performance du système de santé
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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
Apr 25, 2014	2014_267528_0015	H-000684-13,H-000089-14	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

CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581), JESSICA PALADINO (586)

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): April 8, 9, 10, 2014

This inspection was done concurrently with critical incident system inspection #

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, the Resident Assessment Instrument Coordinator
(RAI Coodinator), the Registered Dietitian, the Food Services Manager, Registered Practical Nurses (RPN), Physiotherapy Assistant (PTA), Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspector(s) observed the provision of care, reviewed relevant clinical health records, policies and procedures, and the complaints log.

The following Inspection Protocols were used during this inspection:
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital.

A. Resident #001 was readmitted from the hospital in December 2013. Review of the plan of care revealed a head to toe skin assessment was not completed until seven days after readmission. The assessment documented that the resident had an area of redness since return to facility, a stage two pressure ulcer, and that staff were unsure if the ulcer was present when returned from hospital. Although the resident exhibited altered skin integrity since return to facility, their skin was not assessed upon readmission. Interview with the Director of Care (DOC) and Assistant Director of Care (ADOC), confirmed that the resident's head to toe skin assessment was not completed upon their return from the hospital. [s. 50. (2) (a) (ii)]

2. The licensee did not ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wound, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A. In December 2013, registered staff identified a pressure ulcer on residents #001. Review of the plan of care revealed that weekly wound assessments were not completed by registered staff for three weeks in January 2014. The resident deceased in January 2014, the wound was still present. Interview with the ADOC confirmed that the weekly wound assessments were not completed for the resident.

B. In January 2014, registered staff identified a new pressure ulcer on resident #001's. Review of the plan of care revealed that the weekly wound assessments were not completed by registered staff for three weeks in January 2014. The resident deceased in January 2014, the wound was still present. Interview with the ADOC confirmed that the weekly wound assessments were not completed for the resident. [s. 50. (2) (b) (iv)]

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 any resident exhibiting altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return from hospital, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

A. On an evening in September 2013, resident #008 entered resident #002's room and hit resident #002. The critical incident report indicated that resident #002 did not notify staff of the incident until the following morning. However, the incident was documented in the progress notes for resident #008 on the evening the incident occured. The Power of Attorney (POA) for resident #002 was notified of the incident more than twelve after the original incident occured. Registered staff confirmed that the POA for resident #002 was not notified of the incident within 12 hours of becoming aware of the resident to resident abuse. [s. 97. (1) (b)]

B. In January 2014, a visitor reported that a staff member was rude to resident #004. Review of the critical incident report and home investigation notes revealed that due to the resident's cognitive status, the alleged abuse was not able to be confirmed. Review of the pan of care revealed that the POA for the resident involved in the alleged abuse was not notified. Interview with the ADOC confirmed that as of April 9, 2014, the POA for the resident still had not been notified. [s. 97. (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 the resident's SDM and any other person specified by the resident are notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident., to be implemented voluntarily.

WN #3: 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. (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 did not ensure that the resident was reassessed and the plan of care reviewed and revised at any time when the resident's care needs changed.

A. After three days in the hospital for assessment, resident #001 was readmitted to the home in December 2013 with a diagnosis of pneumonia. Review of the plan of care indicated that the resident's care needs changed, which included intravenous antibiotics, a change in diet, assistance with feeding, and palliative care. The plan of care was not updated to include the assistance with feeding that the resident required and palliative care was not reflected in the plan of care until more than two weeks after return to home. In an interview with the Resident Assessment Instrument Coordinator (RAI Coordinator) it was confirmed that the plan of care was not revised to reflect the care needs of resident #001. [s. 6. (10) (b)]

Issued on this 25th day of April, 2014

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

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