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
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street Suite 403
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Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 18, 2015	2015_273580_0003	018586-15	Critical Incident System

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Waters Edge Care Community
401 WILLIAM STREET NORTH BAY ON P1A 1X5

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

VALA MONESTIME BELTER (580)

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): October 23, 26 and 27, 2015.

The inspector reviewed policies, plans of care and other documentation within the home, conducted a daily walk through of the resident care areas, observed staff to resident interactions and the delivery of care and services to the residents.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), the Director of Care (DOC), and the Administrator.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **1 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	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 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 care set out in the plan of care was provided to resident #001 as specified in the plan.

On October 23 and 27, 2015, Inspector #580 observed resident #001 lying in a non-height adjustable bed with no floor mat in place.

According to the care plan, resident #001 was at a high risk for falls and the care plan identified the interventions of a hi-lo bed and a floor mat to be in place. S #109, S #108, and S #107 identified to the inspector that direction to provide resident care was obtained from the resident's care plan.

S #102, S #107 and S #108 confirmed to the inspector that resident #001 was supposed to have a hi-lo bed. S #107 further stated to the inspector that the bed the resident presently had was a non-height adjustable bed and that this bed could not be lowered. Mid-morning, on October 27, 2015, the inspector and S #102 observed resident #001 in bed with no floor mat in place as specified in the care plan's intervention for this resident's high risk for falls. [s. 6. (7)]

2. According to a Critical Incident Report submitted to the Director, resident #001 had bruising noted which was subsequently diagnosed as a fracture. The report further identified that S #105 used improper care techniques when resident #001 exhibited responsive behaviours.

The inspector reviewed resident #001's care plan which documented that if resident #001 resisted care, staff were to reassure the resident, leave and return five to ten minutes later to try again, and ensure the resident understands the request and care before proceeding.

The inspector reviewed S #106 and S #105's personnel files which indicated that S #105 and S #106 confirmed to the DOC and ADOC, that while carrying out care for resident #001, they had "never seen the resident this upset before", and that despite this, they continued to provide care. According to the same files, the home determined that S #105 and S #106 failed to recognize the escalation of resident #001's agitation level which increased the risk of injury to the resident.

Further documented in S #105's file, the home determined that S #105 failed to recognize the significance of resident #001's responsive behaviours, that S #105 did not follow the responsive behaviour care plan intervention of leaving the resident for five to ten minutes, which resulted in extensive injury.

In an interview with the inspector, S #107 explained that staff received care direction

from the care plan and indicated that sometimes resident #001 exhibited responsive behaviours if the resident was startled and that staff are directed by the care plan, to back away. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of resident #001 was complied with.

According to a Critical Incident Report submitted to the Director, resident #001 had bruising noted which was subsequently diagnosed as a fracture.

The inspector reviewed S #106's and S #105's personnel files in which it was documented that S #105 and S #106 confirmed to the DOC and ADOC, that while carrying out care for resident #001, they continued to provide care for resident #001 despite that they had never seen the resident that upset before. Documented in S #105's file, the home deemed S #105's actions to have been inappropriate and excessive in the circumstances described. Documented in S #106's file, the home deemed S #106 to have been negligent in the provision of a safe environment for the resident. According to the same files, the home deemed that S #105 and S #106 were in violation of the home's policy for Prevention of Abuse and Neglect to a Resident.

The inspector reviewed the home's Prevention of Abuse and Neglect of a Resident policy VII-G-10.00 dated January 2015, which indicated that abuse was defined as improper or incompetent care of a resident that resulted in harm and when the person knew or ought to have known that such behaviour would cause (or could reasonably be expected to cause) harm to the resident's health, safety, or wellbeing; that neglect was defined as the failure to provide the care and assistance required for the health, safety and/or wellbeing of a resident and includes inaction and/or a pattern of inaction that jeopardizes the health, safety, or wellbeing of a resident.

In an interview with inspector, the DOC confirmed that during her interview with S #105, the staff described the incident, and stated that they did not realize that resident #001 would bruise to such an extent or have a fracture. [s. 20. (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 the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a person who has reasonable grounds to suspect that improper or incompetent care that resulted in harm to the resident immediately reports the suspicion and the information upon which it is based to the Director.

According to a Critical Incident Report submitted to the Director, a personal support worker reported to registered nurse (RN), S #110, that resident #001 had bruising which was subsequently diagnosed as a fracture.

In a follow-up phone call, the Director of Care (DOC) explained to the inspector that RN, S #110, reported the incident to the Assistant Director of Care (ADOC) as the DOC was away and that upon the DOC's return to the home, the ADOC reported the incident to the DOC. On October 27, 2015, the DOC indicated to the inspector that the DOC reported the critical incident three days after it had occurred; and that the home was late in reporting the incident to the Director. There was no documentation related to home's internal reporting timelines of the incident.

The inspector reviewed resident #001's health care record which indicated that S #110 documented that a personal support worker reported that resident #001 had bruises, that the personal support worker had first observed this when providing care earlier that morning, that upon assessment of resident #001 by S #110, the staff observed the resident to have significant swelling, bruising, and pain. [s. 24. (1) 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 the person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in risk of harm immediately reports the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

Issued on this 10th day of December, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	VALA MONESTIME BELTER (580)
Inspection No. / No de l'inspection :	2015_273580_0003
Log No. / Registre no:	018586-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 18, 2015
Licensee / Titulaire de permis :	2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP 302 Town Centre Blvd.,, Suite #200, TORONTO, ON, L3R-0E8
LTC Home / Foyer de SLD :	Waters Edge Care Community 401 WILLIAM STREET, NORTH BAY, ON, P1A-1X5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	RUTH GAUTHIER

To 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care is provided to resident #001 and all other residents with responsive behaviours as specified in their plans and to specifically ensure that:
1. The plan of care, including triggers and interventions, is clearly communicated to and understood by all staff and others who provide direct care to the residents;
2. Communication strategies are developed for all staff who provide direct care to a resident so that they are kept aware of the contents of the plan of care; and
3. An auditing process is implemented that identifies when staff are not providing care as specified in the plans so that this can be corrected.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

According to a Critical Incident Report submitted to the Director, resident #001 had bruising noted which was subsequently diagnosed as a fracture. The report further identified that S #105 used improper care techniques when resident #001 exhibited responsive behaviours.

The inspector reviewed resident #001's care plan which documented that if resident #001 resisted care, staff were to reassure the resident, leave and return five to ten minutes later to try again, and ensure the resident understands the request and care before proceeding.

The inspector reviewed S #106 and S #105's personnel files which indicated that S #105 and S #106 confirmed to the DOC and ADOC, that while carrying

out care for resident #001, they had "never seen the resident this upset before", and that despite this, they continued to provide care. According to the same files, the home determined that S #105 and S #106 failed to recognize the escalation of resident #001's agitation level which increased the risk of injury to the resident.

Further documented in S #105's file, the home determined that S #105 failed to recognize the significance of resident #001's responsive behaviours, that S #105 did not follow the responsive behaviour care plan intervention of leaving the resident for five to ten minutes, which resulted in extensive injury.

In an interview with the inspector, S #107 explained that staff received care direction from the care plan and indicated that sometimes resident #001 exhibited responsive behaviours if the resident was startled and that staff are directed by the care plan, to back away. (580)

2. On October 23 and 27, 2015, Inspector #580 observed resident #001 lying in a non-height adjustable bed with no floor mat in place.

According to the care plan, resident #001 was at a high risk for falls and the care plan identified the interventions of a hi-lo bed and a floor mat to be in place. S #109, S #108, and S #107 identified to the inspector that direction to provide resident care was obtained from the resident's care plan.

S #102, S #107 and S #108 confirmed to the inspector that resident #001 was supposed to have a hi-lo bed. S #107 further stated to the inspector that the bed the resident presently had was a non-height adjustable bed and that this bed could not be lowered. Mid-morning, on October 27, 2015, the inspector and S #102 observed resident #001 in bed with no floor mat in place as specified in the care plan's intervention for this resident's high risk for falls.

This compliance order is issued because the identified non-compliance is linked to a serious injury to resident #001 and three past non-compliances about care planning in the last 36 months. (580)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 04, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 18th day of November, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Vala Monestime Belter

Service Area Office /
Bureau régional de services : Sudbury Service Area Office