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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 20, 2016	2016_376594_0003	031752-15, 006212-15, 018122-15	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

MONIKA GRAY (594)

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): January 13-15, 2016.

This inspection included two critical incidents the home submitted related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status, and a critical incident the home submitted related to staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with Residents, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Assistant Director of Care (ADOC), and the Executive Director.

The inspector(s) also reviewed various 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.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Personal Support Services
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 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	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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

A critical incident report submitted to the Director indicated that a resident sustained a fracture after falling while transferring from their bed, because the bed wheels were not locked.

On January 13, 2016, the inspector randomly selected, inspected and observed the following:
- Four beds where the bed wheels and feet were on the ground, the beds moved when leaned against;
- Two beds where the bed feet were on the ground, the beds moved when leaned against.

On January 14, 2016, the inspector observed the following:
- Two beds where the bed wheels were elevated and the bed feet down, the beds moved when leaned against;
- One bed where the bed feet were on the ground, the bed moved when leaned against;
- One bed where the bed wheels and feet were on the ground, the bed moved when leaned against.

On January 15, 2016, the inspector observed in one room, one bed where the bed wheels were not locked and the bed moved when leaned against.

On January 14, 2016, an interview was conducted with PSW #103 and RN #104. Both staff observed one of the beds with the inspector and confirmed the bed should not move when the inspector or the staff leaned against the bed (this was the same pressure applied by the inspector when observing all beds during the course of the inspection). During the same interviews with PSW #103 and RN #104, it was stated that the bed wheels must be locked to prevent the bed from moving.

In an interview with the ADOC, it was confirmed that the bed wheels are to be locked. [s. 5.]

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 each resident's bed system is safe for resident use and does not move, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, a post-fall assessment had been conducted.

The inspector reviewed resident #006's health care record and identified that resident #006 had fallen and only a fall risk assessment had been initiated but not completed.

Review of the home's Falls Prevention Policy # VII-G-30.00 indicated that registered staff will complete an electronic post fall assessment titled Post Fall Huddle.

An interview was conducted with RN #104 and the ADOC. Both staff reviewed the resident's health care record with the inspector and indicated that a Post Fall Assessment had not been completed for resident #006 after they had fallen, as required. [s. 49. (2)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

On January 14, 2016, at 0932 hours the inspector observed at resident #003's bedside table a medication cup containing tablets, capsules and an inhaler.

Review of resident #003's Medication Administration Record for January 14, 2016, at 0800 hours indicated that the resident was administered their medications. According to resident #003's health care record, no medications administered at 0800 hours were permitted to be kept with the resident or in their room.

Review of the home's Resident Self Administration Policy Index# 03-04-10 indicated that if medication is to be left at the bedside or in the resident room, the physician order must specify this.

An interview was conducted with RPN# 100 who confirmed that they left the resident's medications at the bedside, and stated that the resident implied they would take their medication and must have fallen asleep after leaving the resident.

In an interview with RN# 106 and the ADOC, it was indicated that medications were not to be left at the resident's bedside. [s. 129. (1) (a)]

2. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On January 14, 2016, at 0932 hours the inspector observed at resident #003's bedside table a medication cup containing tablets, capsules and an inhaler.

Review of resident #003's Medication Administration Record for January 14, 2016, at 0800 hours indicated that the resident was administered a controlled substance. According to resident #003's health care record, the controlled medication administered at 0800 hours was not permitted to be kept with the resident or in their room.

An interview was conducted with RPN# 100 who confirmed they left the resident's medication at the bedside, and stated that the resident implied they would take their medication and must have fallen asleep after leaving the resident.

In an interview with RN# 106 and the ADOC, it was indicated that controlled medications were not to be left at the resident's bedside. [s. 129. (1) (b)]

Issued on this 20th day of January, 2016

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

Original report signed by the inspector.