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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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
Nov 22, 2018	2018_655679_0028	004573-17, 029714-17, 007523-18, 020869-18, 026055-18	Complaint

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM 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

MICHELLE BERARDI (679), TIFFANY BOUCHER (543)

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): November 5-9, 2018, and November 13-16, 2018.

The following intakes were inspected upon during this inspection:

- One complaint submitted to the Director regarding alleged staff to resident sexual abuse;
- Two complaints submitted to the Director regarding resident care concerns;
- One complaint submitted to the Director regarding the improper discharge of a resident; and,
- One complaint submitted to the Director regarding prolonged call bell wait times.

Critical Incident System Inspection #2018_655679_0029, and Follow Up Inspection #2018_655679_0027, were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Assistant Director of Care (ADOC), Nurse Practitioner (NP), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the Behavioural Supports Ontario (BSO) PSW, residents and their families.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, staff education records, complaint records, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care
Sufficient Staffing

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

2 WN(s)
0 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 or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

In accordance with O. Reg. 79/10, s. 49. (1), the licensee was required to ensure that the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

Specifically, staff did not comply with the licensee's policy regarding "Falls Prevention (VII-G-10.00)", which was part of the licensee's Fall Prevention and Management Program.

A complaint was forwarded to the Director on a specified date, related to resident #005 having a fall, and the substitute decision-maker (SDM) was not notified of the resident falling.

Inspector #543 reviewed resident #005's health care record which indicated that the resident had fallen on a number of specified dates. The Inspector reviewed the resident's "Leisureworld Falls Incident-Post Fall Huddle 2013", that identified that the resident's SDM was not notified at the time of the fall.

Inspector #543 reviewed resident #005's progress notes which identified that the home had a discussion with resident #005's SDM about not being called related to resident #005's fall that occurred on a specified date.

Inspector #543 reviewed the home's "Falls Prevention" (VII-G-10.00) policy which identified that if a resident fell a post fall assessment would be completed. The policy identified that registered staff would notify the resident's substitute decision maker of the fall.

Inspector #543 interviewed RPN #114 who verified that the residents' SDM were always notified of a resident falling.

The Inspector interviewed RN #107 who verified that registered staff were required to notify residents' SDM of a fall, regardless of injury or not. [s. 8. (1) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that before discharging a resident under subsection 145. (1) of the Ontario Regulations 79/10, that the resident and the resident's substitute decision-maker, if any, and any person either of them may direct was kept informed and given an opportunity to participate in the discharge planning and that his or her wishes were taken into consideration; and that a written notice was provided to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justified the licensee's decision to discharge the resident.

According to r. 145. (1) of the Ontario Regulations 79/10, a licensee of a long term care home may discharge a resident if the licensee was informed by someone permitted to do so under subsection (2) that the resident's requirements for care have changed and as a result, the home cannot provide a sufficiently secure environment to ensure the safety of the resident or the safety of persons who come into contact with the resident.

A complaint was forwarded to the Director related to resident #007's discharge from the home.

In a telephone interview with Inspector #679, resident #007's SDM indicated that the home discharged the resident after a specified event. Resident #007's SDM stated that there was no discussion with the home regarding the residents discharge prior to the home discharging the resident.

Inspector #543 reviewed documentation provided by the DOC and Executive Director. The Inspector did not identify any notes or documents to validate that the home provided resident #007's SDM the opportunity to participate in the discharge planning and that their wishes were taken into consideration, nor did the home provide the resident's SDM a detailed explanation of the supporting facts, as they related both to the home and to the resident's condition and requirements for care, that justified the licensee's decision to discharge the resident.

During an interview with the DOC, they DOC verified that the home did not provide the SDM with the opportunity to participate in the discharge planning, nor did they provide a written notice, providing the SDM with a detailed explanation of the supporting facts to justify the home's decision to discharge the resident. [s. 148. (2)]

Issued on this 22nd day of November, 2018

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

Original report signed by the inspector.