Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
Sep 26, 2019	2019_772691_0018	016611-19	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

JENNIFER NICHOLLS (691)

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): September 9 to 13, 2019.

One complaint submitted to the Director regarding resident care concerns was inspected.

A Critical Incident System Inspection (#2019_772691_0017) was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Physiotherapist, Resident Relations Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and their families.

The Inspector 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, complaint records, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Nutrition and Hydration
Pain
Personal Support Services
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

A complaint was submitted to the Director on a specified date related to multiple care concerns specific to resident #001.

Inspector #691 conducted a telephone interview with complainant, who stated that staff rarely use a specified level of assistance for an identified activity of daily living (ADL) for resident #001 as per their care plan, and the nursing staff only offer the resident this type of specified intervention.

During interviews with PSW #104, #113 and RPN #106, #109, #114, it was identified that resident #001 was receiving this specified level of assistance for an identified ADL as it was the resident's preference.

During an interview with resident #001, the resident indicated to Inspector #691 that they preferred the specified intervention for identified ADL and identified that this was their preference.

During review of resident #001's care plan, it was identified that the resident required a different level of assistance for the specified ADL.

A review of policy # VII-C-10.90, titled "Documentation -Plan of care" last revised on April 2019, indicated that a plan of care will be developed and maintained that reflects assessed resident needs according to choice. Current care needs, goals, and

approaches to care will be reviewed and revised in response to the resident's change in care needs, wishes and preferences and goals of care. The policy further indicated to reassess each resident's plan of care as required when resident's care needs change.

In an interview with RN #105, they identified that resident #001 preferred a specified level of assistance for the specified intervention.Together with Inspector #691, RN #105 reviewed the care plan and identified that the care plan indicated that the resident required a different intervention that was being provided. RN #105 identified that the care plan of resident #001 was not updated as per the residents change in preferences and care needs and that it should have been.

Together with Inspector #691, the DOC reviewed resident #001's electronic progress notes in Point Of Care (POC) and the care plan which identified resident #001 used the required identified intervention for a specified ADL as their preference, and indicated that the care plan was not updated reflective of the resident's care needs. [s. 6. (2)]

2. The licensee has failed to ensure that the resident, the Substitute Decision Maker (SDM), if any, and the designate of the resident / SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care.

A complaint was submitted to the Director on specified date, related to care concerns of resident # 001.

Inspector #691 conducted a telephone interview with the complainant, who identified lack of communication from the nursing staff at the home, stating that they were not notified that resident #001 was refusing a specified treatment. They further indicated that they were notified by resident #001's roommate that resident #001 was refusing this specified treatment "all the time." The complainant indicated to the Inspector that resident #001 requested that they, be involved in their care and kept updated of their progress.

Inspector #691 interviewed resident #001 who indicated that the complainant, was to be involved in their care planning and that they would be updated of their progress as required.

Inspector #691 reviewed resident #001's electronic progress notes and it was identified on a specified date by RN#115, that a staff member documented that the resident was experiencing a substantial amount of an identified symptom during their specified treatment and was unable to participate. Further review of progress notes and

documentation by RN#105 indicated on a specific date during care rounds, resident #001 had not participated in the specified treatment, and Inspector #691 could not identify any documentation notifying the complainant of resident #001's refusal of this specified type of treatment and/or change in status.

In an interview with RN #105, they indicated that resident #001 was not progressing with their treatment. RN #105 further indicated to Inspector #691, that they were not sure if the complainant was advised of this update on residents status. Together with Inspector #691, they reviewed the electronic progress notes and could not identify any documentation the complainant was notified of the refusal of this specified treatment and they indicated that they should have been.

In an interview with the staff member, they indicated that resident #001 had been refusing a specified treatment related to an identified symptom.The Inspector reviewed the identified assessment from the specified dates and it was noted that the resident had been refusing specified interventions of this specific treatment during the specified time reviewed. It was further identified by the staff member that the complainant was not updated in resident #001's change in status and identified that they should have been.

Inspector #691 reviewed the home's policy # VIII-A-10.20 titled " Change of Status-Notification of POA/Family, last revised May 2019, which indicated the resident and or SDM shall be notified of changes affecting the resident and/or changes in resident status to ensure ongoing communication between the interprofessional care team and the resident and / or SDM. The policy further indicates, that documentation of the above will be made in the progress notes, including date and time of contact made, name of the person whom notifying as well as reason for notification.

In an interview with DOC, together with Inspector #691, they reviewed the specific assessment for resident #001 as well as electronic progress notes from the specified time and could not locate any documentation updating the complainant of resident #001's change in status. The DOC further indicated that it would be the expectation of the home's nursing staff, as per the home policy to update the complainant with any change in status. [s. 6. (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 ensuring that resident #001 and all other residents of the home, and their Substitute Decision Makers (SDM) and any other persons designated by the resident are given the opportunity to participate fully in the development and implementation of the residents plan of care; and the plan of care of resident #001 is reviewed and revised at any time when care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (1) Every licensee of a long-term care home shall ensure that,
(a) a package of information that complies with this section is given to every resident and to the substitute decision-maker of the resident, if any, at the time that the resident is admitted; 2007, c. 8, s. 78. (1).
(b) the package of information is made available to family members of residents and persons of importance to residents; 2007, c. 8, s. 78. (1).
(c) the package of information is revised as necessary; 2007, c. 8, s. 78. (1).
(d) any material revisions to the package of information are provided to any person who has received the original package and who is still a resident or substitute decision-maker of a resident; 2007, c. 8, s. 78. (1).
(e) the contents of the package and of the revisions are explained to the person receiving them. 2007, c. 8, s. 78. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the admission package given to the resident and SDM at the time of admission.

A complaint was submitted to the Director on a specified date, related to multiple care concerns regarding resident #001.

Inspector #691 conducted a telephone interview with complainant, who stated that on an identified date, resident #001 was admitted. The complainant identified to the Inspector that resident #001 arrived by an identified transfer service at the home during an identified meal service. The complainant further identified that upon arrival to the home they were not received by staff members and indicated that they had to transfer resident #001 into bed without any assistance. The complainant identified to the Inspector that they and the resident did not receive any orientation to the home, or the required admission package.

A review of the home's policy X-C-10.1- (a) titled "Admission Coordinator's checklist", last revised July 2015, indicates that on day of admission, the admissions coordinator will:
-Welcome resident/family, SDM or POA
-Tour resident/SDM of home
-Explain the Admission Package and complete paperwork
-Introduce resident/family to the Director of Care

Inspector #691 interviewed RN # 105 who indicated that on an identified date, resident #001 arrived to the home, via the specified transfer service at a specified time during an identified meal service. They further indicated that the Resident Relations Coordinator #107, was not in the home on the identified day and was unsure if the resident received an admission package as required.

In an interview with Resident Relations Coordinator #108, they indicated to Inspector #691, that resident #001's arrival on the specified date was not "normal protocol during admission to our home". They indicated that they were not in the home on the identified day, but that the expectation as per the home's admission process was for another staff member of the home to meet with resident and family upon their arrival. They further indicated that resident #001 and the complainant did not receive an admission package and they should have as required.

In an interview with the DOC, they indicated to Inspector #691 that they were made aware by the complainant that the homes admission process was not followed and that resident #001 and the complainant did not receive an admission package as required. [s. 78. (1) (a)]

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 admission package is given at the time of admission, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, a response has been made to the person who made the complaint, indicating: i. what the licensee has done to resolve the complaint.

A complaint was submitted to the Director on a specified date, outlining concerns regarding resident #001's admission to the home as well as multiple care concerns.

Inspector #691 conducted a telephone interview with complainant, who identified that resident #001 was admitted to the home on an identified date with no orientation to the home, and no staff to greet them upon their arrival. They further indicated resident #001, did not receive their specified medication due to a communication error at the home with the pharmacy. The complainant identified that they did speak to the management of the home with their concerns as indicated, with no follow up received.

Inspector #691 reviewed a complaint record from the complainant to the home's DOC, from the identified date. The complaint record identified the complainants email which was dated, on the specified date, requesting a meeting to discuss concerns with the home. This email sent by the complainant identified no further details. The Inspector conducted further review of the complaint record which identified concerns regarding lack of communication of nursing staff, receiving no orientation for resident #001 during the admission process, as well the resident not receiving their prescribed medications after arrival to the home, and other care concerns.

A review of policy # XXIII-E-10.00, titled "Complaints Management Program (ON), last revised June 2019, indicated any complaint (verbal, written, telephone, email, or text) received at the care community or at support services office from resident's, families, visitors, and team members shall be investigated, and actions shall be taken for resolution. It further indicates, verbal complaints that can be resolved in 24 hours, the Executive Director or designate will, contact complainant and communicate actions taken to resolve the complaint. As well, ensure that all final resolutions, and every date on which any response was provided to the complainant and description of response.

Together in an interview with DOC, Inspector #691 reviewed the complaint record from the complainant. The DOC identified that they met with the complainant to discuss concerns and the DOC indicated after this meeting, they completed a follow up with the care team from the identified unit. The DOC further identified that they thought they did follow up with the complainant, but on the complaint record, they did not indicate a date or time of any follow up done. They further identified that the home had failed to follow up with the complainant as per policy, to ensure the complaint was resolved and to document the follow up communication as required. [s. 101. (1) 3.]

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 for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, has a response been made to the person who made the complaint, indicating what the licensee has done to resolve the complaint, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to the resident in accordance with the directions for use specified by the prescriber.

A complaint was submitted to the Director on a specified date related to care needs of resident #001. The complainant identified that resident #001 did not receive the specified medications as prescribed upon admission to the home.

Inspector #691 conducted a telephone interview with complainant who indicated that on a identified date, resident #001 was admitted at the home. The complainant further indicated that due to a system error between the pharmacy and the nursing team, resident #001 did not receive their specified medication until an identified date at which time, they went to the homes pharmacy to obtain it. The complainant identified that during this time, they felt that resident #001 did not receive adequate management of their identified symptoms. The complainant further identified that they gave approval to the home as well as the pharmacy for the specified medication.

In a review of policy VIII-E-10.30 titled "Medication Reconciliation", last revised May 2019, indicates that medication reconciliation will be completed within 24 hours for any resident move in and indicates the nurse will follow the process as outlined in the pharmacy manual.

During a review of resident #001's paper chart, the Inspector reviewed the admission/reconciliation orders and noted the Physician order sheet dated on a specific date, indicated the identified medication orders for specific medications ordered to be given to resident #001.The Inspector also noted on the Physician order sheet dated on a specific date, [the complainant] has agreed to pay for the following medications including [the identified medication]. May send to facility".

The Inspector reviewed the Electronic Medication Administration Record (EMAR) for the specified dates which indicated resident #001 did not receive the identified medication as prescribed by the physician, it was noted as not available by nursing staff.

During an interview with RN #103, RN #105, RPN #106 and RPN #109, they identified that the pharmacy would get approval for medication not covered by the home. They also identified that it is part of their homes medication administration process to follow up with the pharmacy if they have not received the medication as ordered by the physician, and if not approved contact the physician for an alternate medication.

During a subsequent interview with RN #105, they identified resident #001's specified medication did not arrive to the home due to a communication system error with the pharmacy and the nursing team on the identified unit. RN #105 reviewed the progress notes of resident #001 on the specific date and identified that the complainant did agree to pay for the identified medication, and further identified that the home did not follow up with pharmacy to ensure the medication was delivered to be given as prescribed.

During an interview with the DOC, they identified to Inspector #691 that resident #001 did not receive their identified medication as per Physician/Reconciliation orders as specified. The DOC further indicated to Inspector #691 that due to internal system error between the pharmacy and the staff at the home resident #001 did not receive the specified medication. The DOC identified that specified medication required approval prior to being sent to the home. Together with Inspector #691, the DOC reviewed progress notes as well as the Physician order sheet both dated on the specific date, identifying that the complainant did agree to pay for the identified medication. They noted no further documentation from staff at the home indicating any follow up with the

pharmacy. The DOC identified that it would be their expectation that the nursing staff would follow up with the pharmacy to ensure the resident received their medication as prescribed, and if approval not attained, the registered staff would contact the physician for an appropriate substitution. [s. 131. (2)]

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 medications are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 30th day of September, 2019

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

Original report signed by the inspector.