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

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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
Jun 23, 2015	2015_301561_0008	H-002251-15	Resident Quality Inspection

Licensee/Titulaire de permis

REGENCY LTC OPERATING LP ON BEHALF OF REGENCY
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

THE WATERFORD
2140 Baronwood Drive OAKVILLE ON L6M 4V6

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

DARIA TRZOS (561), CATHIE ROBITAILLE (536), KATHLEEN MILLAR (527), MICHELLE WARRENER (107)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): April 7-10, April 14-16, April 20-22, 2015

The following critical incident inspections were completed during the RQI: H-001975-15, 002347-15, 000744-15, H-002089-15. The following complaint inspection was completed with this RQI: H-001645-14 and a separate complaint inspection report issued with an inspection number 2015_301561_0009 / H-001523-14. The following non-compliance r. 36 was issued during the following inspection, H-001523-14 and contained in the RQI report.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC)/Acting Administrator, Chartwell Administrator from another home, Assistant Director of Care (ADOC), Environmental Services Manager (ESM), Program and Support Services Manager, Corporate Dietitian, Food Services Manager, Dietary Aides, RAI-MDS Coordinator, Physiotherapist, Director of Social Services, Business Manager, Resident Council President, Behavioral Support Ontario (BSO), IPAC / Wound & Skin Lead, Registered Staff including Registered Nurse (RNs) and Registered Practical Nurses (RPNs), Personal Care Providers (PCPs), family members and residents.

During the course of the inspection, the inspectors toured the home, observed the provision of care, observed the meal service, reviewed health care records, reviewed relevant policies, procedures and practices, laundry, maintenance and housekeeping practices, and food production systems, interviewed residents, family members and staff.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **8 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 O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning techniques when assisting residents.

A) Resident #044 had a fall on an identified date in 2014. Staff members lifted the resident manually from the floor into the wheelchair. The home's policy called "Safe Transfer Program", policy number CCHR-E-09, revised November 2014, indicated that "there is no manual resident lifts permitted (therefore there are no resident lifts physically done by the employee(s))".

The DOC confirmed that staff were required to use a lift when lifting the resident off the floor. The home did not ensure that the staff used safe transferring techniques to lift the resident from the floor after the fall. (561)

B) The written plan of care for resident #006 stated that the resident required two person extensive assistance with transfers. On an identified date in 2015, resident #006 was transferred by one PCP leading to falling; and sustaining an injury. The homes investigation notes identified that the PCP was not aware that resident was a two person transfer. The resident was interviewed by the LTC Inspector on an identified date and was able to recall the details of the incident.

The PCP had received training in 2014, on Transferring Practices in Long Term Care.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 staff use safe transferring and positioning techniques when assisting residents., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #006 was cared for in a manner consistent with his or her needs.

On an identified date in 2015, resident #006 told the PCP that they needed a second staff member to assist with the transfer from the toilet, to the wheelchair. The PCP providing care encouraged the resident, telling them that they could do it with their assistance. During the transfer, the resident lost balance and sustained an injury. The written plan of care for resident #006, stated that the resident required, two person extensive assistance with transfers. The PCP failed to ensure that resident #006 was cared for in a manner consistent with their needs. This was confirmed by the DOC on April 16, 2015. [s. 3. (1) 4.]

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 resident is cared for in a manner consistent with his or her needs, 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of residents so that their assessments were integrated, consistent with and complemented each other.

A) Resident #043's bed system was assessed and tested in June 2014 as part of the Annual Bed Assessment and Testing by the Environmental Services Manager (ESM) prior to the resident's admission. The bed assessment and testing identified the resident's bed had quarter bed rails on both sides. The Bed System Assessment conducted in December 2014 by registered staff identified that the resident needed both bed rails up when in bed to assist with turning and mobility; however, the type and size of bed rails were not identified. The Minimum Data Set (MDS) Assessment conducted by registered staff in December 2014 identified the resident needed full bed rails on all open sides of their bed. The MDS Assessment also identified the resident was at high risk for falls. The resident subsequently had a fall over the bed rails with no injury on an

identified date in 2014. The resident had another fall over the bed rails and sustained a significant injury. The resident's daily flow sheets were reviewed and identified the resident had partial bed rails. The written plan of care and kardex were reviewed and identified bed rails on both sides of the resident's bed; however, no type or size of bed rails were identified. The PCP who provided care to resident #043 was interviewed and confirmed the resident had full bed rails on both sides of the bed. The ESM was interviewed and confirmed that based on their annual bed assessment the resident's bed had one quarter bed rail. The DOC and ESM confirmed the Annual Bed Assessment and testing completed June 2014 was shared with the registered staff on each unit, which the staff were expected to include in the resident's Bed System Assessment in December 2014. The DOC, ESM and registered staff confirmed their assessments were not integrated, consistent with, and complemented each other. (527)

B) Resident #045's continence assessment completed in December 2014, stated there was no history of an identified medical diagnosis; however, the resident was treated for this medical diagnosis a month prior to that assessment.

The continence assessment completed in December 2014, stated the resident wore a specified colour rief; however, the resident wore a different colour brief as of November 2014, as indicated on their care plan. The care plan was not changed to include a change in the colour of brief between November and December when the continence assessment was completed. The two documents were not consistent.

The continence assessment in December 2014 indicated the resident was consuming an average of 1500 ml per day with adequate hydration; however, the resident's intake identified on the food and fluid intake records prior to the continence assessment, indicated a lower than a target average per day when their target fluid requirement was 1500 ml per day. The resident's recorded intake was not consistent between the two areas. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

A) Resident #001’s MDS assessment for January 2015 and the ONT-Bowel Function Assessment in February 2015 indicated that the resident had a change in bowel continence from being continent of bowel to occasionally incontinent of bowel. The written plan of care was reviewed and did not address the bowel incontinence. The interview with registered staff and the ADOC confirmed that the staff did not document in

the written plan of care the change in bowel continence for resident #001 when there was a change.

B) Resident #012’s ONT-Bowel Function Assessment on admission in 2014, indicated that the resident was usually incontinent of bowel. The ONT-Bowel Function Assessment in January 2015 indicated that the resident was occasionally incontinent of bowel. The written plan of care from January 2015 indicated that the resident was usually incontinent of bowel. The ADOC confirmed that the change was not documented in the written plan of care at the time of assessment. [s. 6. (9) 1.]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident’s care needs changed or care set out in the plan was no longer necessary.

A) Resident #017 was identified on the MDS Assessment in July 2014 that they had adequate vision. In October 2014 the assessment identified the resident's vision had deteriorated to moderately impaired vision. The Resident Assessment Protocol (RAP) from October 2014 and January 2015 identified the resident no longer used eyeglasses. The RAP identified the resident was prone to loosing the eyeglasses due to a decline in the resident's cognitive condition. The RAP in October 2014 and January 2015 also identified that the change in visual function was addressed in the plan of care with staff and family input. There were no interventions or strategies identified in the plan of care in October 2014 or January 2015 to address the change in visual function. The clinical record was reviewed and identified there were no changes to the plan of care when the resident was reassessed in October 2014 and January 2015. The PCPs and the RN were interviewed and they confirmed the resident lost their glasses. The staff also confirmed the resident had a change in visual function in October 2014 and the plan of care was not reviewed and changed to address the resident's care needs.

B) The MDS Assessment in November 2014 for resident #019, identified adequate vision and no RAP was triggered. Subsequently, on an identified date in 2015 the quarterly MDS Assessment identified the resident's vision had changed and the resident's vision was highly impaired. This assessment triggered a RAP, which identified that the new RAP was addressed in the written plan of care. The RAP identified that staff were to call the resident's name when approaching for care and ensure the environment was clutter free. It further elaborated that the RAP will be care planned with interventions to support the resident's vision impairment. The written plan of care and kardex were reviewed and vision care was not revised to identify the interventions to support the resident's vision

impairment. The registered staff and PCPs confirmed the change in the resident's vision and there were no interventions identified based on the assessment. The DOC confirmed that staff were expected to review and revise the written plan of care and kardex when the resident's care needs changed. [s. 6. (10) (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 staff and others involved in the different aspects of care collaborate with each other in the assessment of a resident so that their assessments are integrated, consistent with and complement each other; to ensure that the provision of care set out in the plan of care is documented and to ensure that that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when resident's care needs change or care set out in the plan is no longer necessary., to be implemented voluntarily.

WN #4: 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 the home's policy called "Hydration Program", policy number LTC-CA-WQ-300-05-07, revised July 2014 and January 2015, was complied with by staff providing care to resident #045.

A) The policy stated, "If a resident's intake is 1000 ml fluid or less for 3 consecutive days the resident will be referred to the Registered Dietitian (RD) unless: a. The RD has seen the resident for the same reason in the last 30 days and has revised the care plan with appropriate interventions if needed, or, b. The RD has stated that fluid intake 1000 ml or less is resident appropriate."

B) The resident's food and fluid intake records reflected a fluid intake of 1000 ml or less during identified dates in October and December 2014. The resident required 1500 ml minimum.

C) A referral for poor fluid intake was not initiated on any of these dates and the resident had not been reviewed for poor hydration with interventions initiated within the 30 days prior.

D) The Registered Dietitian confirmed that they did not receive any referrals related to the poor hydration on the identified dates and confirmed that the resident's target intake was more than 1000 ml per day.

E) The home's policy was not followed in relation to referral to the Registered Dietitian for fluid intake of 1000 ml or less during identified dates in October and December 2014. [s. 8. (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 home's policies are complied with by staff providing care to residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rules were complied with: 2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

During the resident observations in Stage 1 of the Resident Quality Inspection (RQI) the door to the mud room on one of the units was unlocked and accessible to residents with dementia. The inner core of the door lock system was missing and paper towel was stuffed into the latch of the door; therefore the door could be pushed open by residents. The mud room also housed a laundry chute with a latch that could be easily opened by residents and it was not locked.

The DOC was notified immediately, and stationed a PCP at the unlocked mud room door. The LTC Inspector reviewed the Maintenance Log and identified that the broken lock on the mud room door was reported in February 2015 by staff on the unit. The Maintenance Manager was interviewed and stated he was waiting for a door lock part to be delivered and then the lock would have been repaired. The mud room door was broken, unlocked and accessible to residents from February to April 2015. The staff were interviewed and identified the door was broken and unlocked for at least one to two weeks, and confirmed it was reported in the Maintenance Log. The DOC confirmed the safety risk to residents and was not aware the door had not been repaired. The mud room door was repaired and locked within 15 minutes of the Maintenance Manager being notified of the high risk to residents. [s. 9. (1) 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 ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #6: 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 residents, was complied with.

Resident #017 had a visitor on an identified date in 2015. The registered staff and a PCP witnessed the resident being physically assaulted by the visitor. The home immediately removed the visitor from the unit. The resident was not injured; however the resident was upset. The visitor denied the action. The witnessed incident was not reported to the Director until three days after the incident. The home's policy called "Resident Abuse - Abuse Prevention Program - Whistle-Blowing Protection", policy number LTC-CA-ALL-100-05-42, revised October 9, 2014 identified "immediate notification/mandatory reporting to the governing provincial authority as applicable to the home, province and sector". The registered staff confirmed they were expected to immediately report physical abuse to the Ministry of Health and Long Term Care (MOHLTC), and they were trained on the home's policy and expectations to immediately report. The DOC confirmed they did not report the physical abuse immediately; therefore they had not complied with their policy.

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 #7: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there were schedules in place for routine, preventative and remedial maintenance.

During the initial tour of the home it was observed that majority of the door frames were scraped on Sheridan, Oakville, Trafalgar and Palermo home areas, and the door to the mud room on Appleby home area. The ESM confirmed that the door frames needed to be repainted and confirmed that there was no schedule in place for routine painting of the door frames. [s. 90. (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 there are schedules in place for routine, preventative and remedial maintenance, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were labeled properly and were kept inaccessible to residents at all times.

On April 7, 2015, the door to the mud room on one of the units was identified as being unlocked and accessible to residents with dementia. The inner core of the door lock system was missing; therefore the door could be opened by residents. In the mud room the LTC Inspector found a large container of caustic solution sitting on the counter with a pump, which was identified on the manufacturer's label as being dangerous if ingested. In addition, there was a bottle of disinfectant under the sink, which also was identified on the label as dangerous if ingested. The staff and DOC were notified and a PCP was stationed at the unlocked door until the lock was repaired by Maintenance. The mud room was unlocked and accessible to residents on the dementia unit from February to April 2015. The DOC and staff confirmed the safety risk to residents, and the DOC was not aware that the door had not been repaired. The mud room door was subsequently repaired by the Maintenance Manager within 15 minutes of being notified of the high risk to residents. [s. 91.]

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 all hazardous substances at the home are labeled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #045 was bathed twice a week by the method of their choice.

The resident #045's plan of care was revised in October 2014 to include the resident's and family's request for a tub bath instead of a shower. Registered and front line nursing staff were aware that the resident preferred a tub bath when interviewed by the inspector. Documentation on the resident's flow sheets for October 2014 to January 2015 indicated the resident received a shower instead of a bath on 14 days between those months. During interview, nursing staff stated that when casual or part time staff worked they often gave a shower without being aware of resident's preference for a bath. The resident was unable to voice their preference to staff due their impairments. [s. 33. (1)]

WN #10: 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,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #015 who was dependent on staff for repositioning every two hours was repositioned.

The written plan of care for resident #015 specified that the resident was to be turned and positioned every 2 hours to offload pressure to their wound. A review was completed, of the Point of Care (POC) turning and repositioning schedule for an identified month in 2015 for resident #015. During the identified month in 2015, there were thirty five separate incidents, were the documentation identified several hours between turning and repositioning times for resident #015. The wound was documented as improving however, the documentation did not reflect that repositioning was occurring every 2 hours as per the plan of care. This was confirmed by the Quality Care Co-Ordinator who was responsible for the skin and wound program at that time. [s. 50. (2) (d)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #045, who had a decline in bowel continence from occasionally incontinent to full incontinence, had a continence assessment that was completed using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence, when the change occurred.

The resident's continence declined after hospitalization in 2015. The MDS Assessment in November 2014, coded a change in continence from occasionally incontinent to total incontinence for bowels; however, an assessment using a clinically appropriate assessment instrument specifically designed for assessment of incontinence was not completed until December 2014, when the scheduled quarterly assessment was due. Registered staff confirmed that the bowel and bladder incontinence assessments on Point Click Care (PCC) were required to be completed after there was a change in the resident's condition and would not be delayed until the regularly scheduled quarterly review. During interview, registered staff stated that some of the assessments did not get completed on time. The home's policy called "Readmission of Resident from LOA, Hospital or Other", policy number LTC-CA-WQ-100-02-08, revised November 2014, also confirmed that after a "significant change" in resident status the bladder and bowel function assessments in PCC were to be completed. [s. 51. (2) (a)]

WN #12: 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 has failed to 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.

On an identified date in 2015 resident #017 was physically abused as witnessed by the charge nurse and a PCP. The home assessed the resident, initiated their investigation, notified the physician; however the Substitute Decision Maker (SDM) was not notified until two days after the incident. The DOC confirmed the resident's SDM was not notified according to their policy and legislative requirements. The clinical record and critical incident investigation notes identified the SDM was not notified within 12 hours of becoming aware of the abuse. The SDM confirmed that they were not notified of the incident until the police had come in to interview the resident. [s. 97. (1) (b)]

WN #13: 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 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.

During Stage 1 of the RQI a family interview was conducted with the Power of Attorney (POA) for resident #019. The POA identified that they do the laundry for the resident since being admitted to the home. However, some of the resident's clothing items had gone missing. The POA identified they telephoned the charge nurse and reported the missing laundry. The POA stated that no one offered to look or go to the laundry to search for the missing laundry. The charge nurse and DOC confirmed that it was the staffs responsibility to complete the Missing Laundry form when they receive a complaint of missing laundry from a POA, initiate a search of the resident's unit, and if the item(s) were not recovered during the search then the ESM would be contacted to initiate a search in the laundry services area. The home's policy called "Complaints", policy number LTC-CA-WQ-100-05-09, revised November 2014, identified that if verbal complaints were not resolved within 24 hours of receipt of the complaint by staff that a written documentation of the investigation and the communication associated with the complaint will be completed. Upon review of the home's complaint log there was no documentation of this complaint of missing laundry for resident #019. Review of the resident's clinical record revealed there was no documentation of the complaint of missing laundry as identified by the POA and charge nurse. The POA confirmed there was no response from the home related to her complaint of missing laundry or what was done to resolve the complaint. [s. 101. (1) 3.]

Issued on this 4th day of August, 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) :	DARIA TRZOS (561), CATHIE ROBITAILLE (536), KATHLEEN MILLAR (527), MICHELLE WARRENER (107)
Inspection No. / No de l'inspection :	2015_301561_0008
Log No. / Registre no:	H-002251-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 23, 2015
Licensee / Titulaire de permis :	REGENCY LTC OPERATING LP ON BEHALF OF REGENCY 100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1
LTC Home / Foyer de SLD :	THE WATERFORD 2140 Baronwood Drive, OAKVILLE, ON, L6M-4V6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Paul Taylor

To REGENCY LTC OPERATING LP ON BEHALF OF REGENCY, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the home uses safe transferring and positioning techniques when assisting residents. The plan is to include but is not limited to:

-the development and implementation of a protocol mitigating the risk when transferring and positioning residents.
-A mechanism to ensure that staff are made aware of the care specified in the care plans for residents under their care.
-A schedule for ongoing monitoring of staff in the provision of care to residents and ensuring that care identified in the care plan is provided.

The plan is to be submitted on or before July 15, 2015 by mail to Cathie Robitaille at 119 King Street West, 11th Floor, Hamilton, Ontario, L8P 4Y7 or by email at Cathie.Robitaille@ontario.ca.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A) Previously issued non-compliance in September 2013 as a VPC.

B) Resident #044 had a fall on an identified date in 2014. Staff members lifted the resident manually from the floor into the wheelchair.

The home's policy called "Safe Transfer Program", policy number, CCHR-E-09, revised November 2014, indicated that "there is no manual resident lifts permitted (therefore there are no resident lifts physically done by the employee (s)).

The DOC confirmed that staff were required to use a lift when lifting the resident off the floor. The home did not ensure that the staff used safe transferring techniques to lift the resident from the floor after the fall.

(PLEASE NOTE: This evidence of non-compliance related to the above noted non-compliance was found during inspection # 2015_301561_0009 / H-001523-14.

C) The written plan of care for resident #006 stated that the resident required two person extensive assistance with transfers. On an identified date in 2015, resident #006 was transferred by one PCP leading to the resident falling; and sustaining an injury. The homes investigation notes identified that the PCP was not aware that resident was a two person transfer. The resident was interviewed by the LTC Inspector and was able to recall the details of the incident.

The PCP had received training in 2014, on Transferring Practices in Long Term Care. (536)
(561)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2015

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

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 23rd day of June, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Daria Trzos

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