Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

**Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue**


**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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| Date(s) of inspection/Date(s) de l'inspection | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| Jun 2, 9, 2011 | 2011_064167_0003 | Critical Incident |

**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**

MARILYN TONE (167)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident inspection.**

**During the course of the inspection, the inspector(s) spoke with The Administrator, the Director of Care and nursing staff on the unit.**

**During the course of the inspection, the inspector(s) Conducted a review of the health files for two residents at the home, reviewed the home's policies related to responsive behaviours and prevention of abuse and neglect.**

**The following Inspection Protocols were used in part or in whole during this inspection:**

**Responsive Behaviours**

**Findings of Non-Compliance were found during this inspection.**

## NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

| Definitions | Définitions |
|---|---|
| WN – Written Notification | WN – Avis écrit |
| VPC – Voluntary Plan of Correction | VPC – Plan de redressement volontaire |
| DR – Director Referral | DR – Aiguillage au directeur |
| CO – Compliance Order | CO – Ordre de conformité |
| WAO – Work and Activity Order | 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.)<br><br>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.<br><br>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. 53. Responsive behaviours**

**Specifically failed to comply with the following subsections:**

**s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,**
**(a) the behavioural triggers for the resident are identified, where possible;**
**(b) strategies are developed and implemented to respond to these behaviours, where possible; and**
**(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).**

**Findings/Faits sayants :**

1. Two residents reviewed did not have behavioural triggers identified on the document that the home refers to as the care plan.
No strategies were found to be developed and implemented on the document that the home refers to as the care plan to respond to the responsive behaviours demonstrated by these two residents.

a) The documentation in the progress notes for an identified resident indicates that they resist care, are aggressive, pace, dress inappropriately and have altered sleep patterns.
None of these behaviours were identified on the document that the home refers to as the care plan for the identified resident and no interventions were present on the care plan to respond to these behaviours.
b) The document that the home refers to as the care plan for another identified resident does not include their potential for responsive behaviour/aggression.

***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 each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified and strategies are developed and implemented to respond to these behaviours, where possible. , to be implemented voluntarily.***

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents**
**Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,**
**(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and**
**(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.**

**Findings/Faits sayants :**

1. The licensee did not identify steps to be taken to minimize the risk of altercations and potentially harmful interactions between two residents including identifying and implementing interventions.

a) One identified resident can become very aggressive when feels provoked. On one occasion an altercation took place the resident and another identified resident resulting in the second resident sustaining an injury. Suggested interventions related to making staff aware of the need to keep these residents apart were never entered in to the document that the home refers to as the care plan for either resident.
b) One resident currently has an intervention in place to discourage other residents from entering their room. This intervention is not documented in the document that the home refers to as the their care plan.
c) The document that the home refers to as the care plan for an identified resident does not identify the need for heightened monitoring activities.
d) An interview with a personal support worker staff on the unit revealed that when an identified resident begins to pace and wander during the night, staff often will have them sit with them at the nurses' station to monitor more closely. This intervention is not included in the document that the home refers to as the care plan for the identified resident.

***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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions., to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

**Specifically failed to comply with the following subsections:**

**s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).**

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**Findings/Faits sayants :**

1. The licensee did not protect a resident from abuse by a co-resident.

a) On one occasion an identified resident was injured during an altercation with a co-resident.

***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 are protected from abuse, to be implemented voluntarily.***

**Issued on this 21st day of July, 2011**

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

Marilyn Lore