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
Jun 23, 2015	2015_301561_0009	H-001523-14	Complaint

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)

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): April 20, 21, 22, 2015

This inspection was completed along with the Resident Quality Inspection (RQI), inspection #2015_301561_0008 / H-002251-15. A non-compliance was identified in this inspection related to r. 36 and included in the RQI report.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Physiotherapist, Restorative Care Coordinator, RAI-MDS Coordinator, Registered Staff, Personal Care Providers (PCPs) and family.

During the course of the inspection the inspector observed the provision of care, reviewed health care records, reviewed relevant policies, procedures and practices, interviewed family members and staff.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 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:
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that the resident had a designate person receive information concerning any transfer or hospitalization of the resident immediately.

Resident #044 had a fall on an identified date in 2014 and was transferred to the hospital. The resident’s Power of Attorney (POA) had left an alternate number with the home in case of an emergency. When the resident fell and was transferred to the hospital the home had tried to notify the POA about the incident but was unable to reach them. The DOC reported in April 2015 that the registered staff who took down the information with the alternate number did not update the resident’s plan of care and the staff were not aware that there was an alternate number provided in case of an emergency. Staff were not aware of this information and could not reach the POA to notify them of the hospitalization. According to progress notes the POA was reached the following day. The home did not ensure that the resident's POA was immediately notified of the resident transfer to the hospital. [s. 3. (1) 16.]

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 every resident has the right to designate a person to receive information concerning any transfer or hospitalization of the resident and to have that person receive that information immediately, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).

s. 24. (9) The licensee shall ensure that the resident is reassessed and the care plan is reviewed and revised when,
(a) the resident's care needs change; O. Reg. 79/10, s. 24 (9).
(b) the care set out in the plan is no longer necessary; or O. Reg. 79/10, s. 24 (9).
(c) the care set out in the plan has not been effective. O. Reg. 79/10, s. 24 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the 24-hour admission care plan identified the resident and included, at minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks.

Resident #044 was admitted to the facility on an identified date in 2014. The Admission Assessment indicated that the POA requested the bed to be at lowest position for resident as the resident had a history of climbing out of bed. The POA reported that on many occasions when they visited the resident, the bed was not at the lowest position. The staff were interviewed and indicated that they were aware that resident required to have the bed in the lowest position. The 24-hour care plan was reviewed and did not address the potential risks related to falls and did not include the bed to be in lowest position. The DOC confirmed that the intervention to place the bed in lowest position was not added to the 24-hour care plan.

The home did not ensure that the 24-hour care admission care plan included the potential risk of falling and the intervention that was requested by POA. [s. 24. (2) 1.]

2. The licensee has failed to ensure that the resident's care plan was revised when the care needs changed during the 21 days of the development of a complete care plan.

A) Resident #044 was admitted to the facility on an identified date in 2014. After the 7

day observation period, Minimum Data Set (MDS) Assessment was completed and the Resident Assessment Protocol (RAP) was generated. According to the RAP completed after admission the resident was triggered for falls and indicated that the resident was at high risk for falls. The RAP also indicated that the care plan will be developed to address the falls risk and interventions would be developed to address the risk.

On an identified date in 2014 after the RAP was completed, resident walked out of their room, lost balance and fell in the hallway. Prior to the fall the resident did not demonstrate wandering behaviours and according to the staff this was the first time the resident got out of bed and attempted to walk on their own. The resident had no previous documented falls.

Health care records that were reviewed during the inspection indicated that the care plan did not address the resident to be at high risk for falls until after the fall occurred. During the time when the resident was monitored and care plan was being developed the resident's bed was placed in the lowest position as requested by POA. The health care records indicated that there were no other interventions developed to address the risk for falls prior to the fall even though the RAP indicated the resident was at high risk for falls.

The home’s policy called "Resident Safety and Risk Management", policy number LTC-CA-WQ-200-07-08, revised November 2014, indicated that "upon completion of the admission MDS assessment, staff is to review the triggered RAP’s. If the Fall RAP is triggered staff are to complete the Morse Risk Assessment in Point Click Care. Staff will then determine what level the resident is at risk for falling and use the information obtained through the assessments to complete a resident specific care plan related to fall risk”. The home had completed the physiotherapy assessment, bed system assessment and the Morse Risk Assessment. The Morse Risk Assessment indicated that the resident was at high risk for falls but the home did not complete a resident specific care plan related to the fall risk. This was also confirmed by the DOC.

The licensee did not ensure that when resident was assessed the care plan was revised to address the potential of risk to the resident in relation to falls.

B) The Bed System Assessment that was completed after admission of resident #044 indicated that the resident required two half rails applied for bed mobility and positioning assistance and were consented by family. A PCP indicated that the resident had bed rails applied while in bed. The Flow sheets were reviewed and indicated that staff were documenting that bed rails were applied for resident while in bed. The resident’s care

plan was reviewed and did not indicate that the resident used bed rails for bed mobility and positioning. The DOC confirmed that any changes to resident's care during the 21 days of developing the written plan of care must be added to resident's care plan.

The licensee did not ensure that when the resident was assessed the care plan was revised when the resident's care needs changed. [s. 24. (9) (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 24-hour admission care plan must identify the resident and must include, at minimum, the following with respect to the resident: 1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks and to ensure that the care plan is revised when the care needs change., to be implemented voluntarily.

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.