Ontario

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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7

Telephone: 905-546-8294
Facsimile: 905-546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
Hamilton ON L8P 4Y7

Téléphone: 905-546-8294
Télécopieur: 905-546-8255

☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
November 22, 23, 2010	2010-173-2908-22Nov101500 2010-192-2908-22Nov113454 2010-192-2908-22Nov101522	H01979, H02166, H02224, H02420, H01552

Licensee/Titulaire
Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
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(s)
Lesa Wulff – Nursing - #173, Debra Saville – Nursing - #192

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct two critical incident inspections and one complaint inspection.

During the course of the inspection, the inspectors spoke with: Administrator, Director of Care, RAI-Coordinator, Registered staff, Personal Support Workers (PSW's) and Residents.

During the course of the inspection, the inspectors: reviewed policy and procedures, reviewed clinical health records, reviewed medications and observed care of residents.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse and Neglect Inspection Protocol
Responsive Behaviours Inspection Protocol

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

7 WN
6 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8 s.3(1)1,4
Every licensee of a long term care home shall ensure that the following rights of residents are fully respected and promoted:
(1)Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
(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.

Findings:

1. An identified resident was not treated with respect in relation to the following: the resident reported to the management of the home that an altercation with a staff member had occurred. The resident reported that the staff member was rude, shut a door in the residents face and then made another upsetting comment to the resident when providing care. The resident stated during interview, this was very upsetting and the resident had never been spoken to like that in years. Documentation showed that the resident was upset on the day of the altercation and staff had to provide comfort to the resident, as the resident was crying and also needed a medication. This was confirmed by witnesses to the incident and statements taken by the management of the home during their investigation of the allegations.
2. An identified resident was not treated with courtesy, respect and dignity in relation to the following: During review of documentation for the resident, it was noted that this resident sustains numerous injuries as a result of responsive behaviours. Progress notes also state that staff have injured the resident with the mechanical lift, bumping the lift into the residents head. It was reported to writer that injury has occurred with the resident due to rushed and distracted staff and that staff do not pay attention to the signals of the residents resisting care and continue to force care upon the resident even when the resident is fighting. It was reported that there are a lot of bruises on the on resident due to forced care. It was reported to writer that this has been witnessed on many occasions with different staff. It was also reported that bruising on the residents arm, is suspected to be at the level of the table tray and is caused by staff pushing the tray on, sometimes hitting the resident's forearms in the process.
3. A specified resident indicated that "on several occasions" when asking for assistance staff responded negatively and in a manner that created embarrassment for the resident.

4. Progress notes indicated that a specific resident returned from a program requiring assistance and was subsequently forced to wait 40 minutes before assistance was provided. The resident complained of discomfort at the time, and subsequently developed a Urinary Tract Infection (UTI). The care team did not meet this resident's individual needs in a courteous and respectful manner.
5. An identified resident's condition changed upon return to the home from hospital. The change in condition was documented by Registered Staff but no action was taken to assess resident or intervene until the resident required transfer to hospital once more.

Inspector ID #:	173

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 related to developing a plan to ensure that all resident are to be treated with courtesy, respect and dignity by staff at all times, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8 s.6(10)(b)(c)
The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every 6 months and at any other time when:
(b) the resident's care needs change or care set out in the plan is no longer necessary;
(c) care set out in the plan of care has not been effective.

Findings:

1. An identified resident is noted to have ongoing resistive behaviours. The resident is resistive to personal care, taking medications and general touch by staff due to the resident's cognitive impairment. During interview, it was reported that the resident misinterprets staffs actions, and will resist and fight staff as a misguided self defense mechanism. It was indicated that the resident responds well to certain staff that understand this and are willing to provide slow gentle care. The plan of care for the resident states that this resident is both verbally and physically aggressive. Staff during interview, indicate that the resident is not physically aggressive, the resident is responsive. Resident assessment protocol (RAP) dated October 24, 2010 states that the resident's behaviours impact on the staff's ability to provide necessary care. Interventions have not been effective in delivering care to the resident to date, which results in frequent multiple bruises on the resident. The plan of care has not been reviewed or revised as a result of interventions that have not been effective.

Inspector ID #:	173

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 related to developing a plan to

ensure that all plans of care are reviewed and revised when they are not effective, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8 s.6(1)c
Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out:
(c) clear directions to staff and others who provide direct care to the resident.

Findings:

1. Plan of care for an identified resident indicates that this resident is verbally and physically aggressive related to dementia and another diagnosis. During staff interviews; staff indicate the resident is not verbally or physically aggressive; the resident is verbally and physically responsive. The resident is only resistive during care and does not seek out or engage staff or other residents verbally or physically at other times. It was reported that cooperation increases with the correct approach from staff. This has not been identified in the plan of care with interventions to facilitate safe care for the resident and staff.
2. The plan of care goal in place currently is to ensure safety for the resident and staff. The goals for this resident do not include reducing behaviours to ensure care can be performed and injury to resident prevented.
3. Interventions in place on this resident's plan of care are not appropriate as they are geared toward a physically aggressive resident. Interventions include: staff are to recognize and avoid behaviours that provoke aggressive behaviours, Allow resident time to respond to directions or requests and stay with resident during periods of anger if appropriate or if the resident wishes. Interventions do not provide clear direction to staff in order to complete the residents care, ensure safety of the resident and reduce responsive behaviours.
4. The plan of care demonstrates conflicting information related to a specified resident's abilities and direction for staff.
5. The documented plan of care for a specified resident does not reflect the care received as identified during interview with the resident and a PCP.
6. The plan of care (Mobility) for a specified resident indicates that the resident is to be turned and repositioned every 2-3 hours when in bed. During interview, the resident identified that turning and repositioning is not required.

Inspector ID #:	173

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 related to developing a process to ensure that the plan of care gives clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10 s.8(1)b
Where the Act or 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 the plan, policy, protocol, procedure, strategy or system:
(b) is complied with

Findings:

1. Resident abuse policy LTCE-RCA-A-E-002, states that all staff are to report any abuse immediately to the Administrator, Director of Care or designate. A staff member was aware of financial abuse of a resident in 2010 and did not report it to the management team. This was verified in the staff member's statement found in the investigation package share by the management team of the home.
2. Resident abuse policy LTCE-RCA-A-E-002, states that all residents are to be treated with courtesy and respect. An identified staff member was involved in an altercation with a resident, in which the resident provided a written statement. The resident states that the staff member ignored the resident, shut a door in the residents face and then told the resident that the staff member would never be a friend to the resident when the resident tried to apologize. The resident stated during interview, this was very upsetting and that the resident had never been spoken to like that in years. Documentation show that the resident was upset on the day of the altercation and staff had to provide comfort to the resident, the resident was crying and also needed a medication.
3. Behaviour management policy NUR-V-14 states that resident assessment will include identifying behavioural problems, care planning will include interventions appropriate to the individual designed to minimize disturbed behaviours, interventions are evaluated for effectiveness, care is reassessed on a continuing basis. This will be accomplished through individual resident assessments and analysis of incidents. Staff should be aware and sensitive to the resident's behaviour patterns. Due to ongoing responsive behaviours, assessments, analysis, development of interventions and evaluation for effectiveness did not take place for an identified resident related to responsive behaviours.
4. Documentation policy LTCE-RCA-D-006 states that PSW's are to report observations to registered staff who will document these observations and any follow up in the resident's progress notes. Family members of an identified resident reported bruising found on the resident's arms to registered staff. Documentation indicates that when the registered staff questioned the personal support workers, they told the registered staff that they were aware of the bruising and had seen the bruising on the resident during the resident's bath three days prior. This was not reported to the registered staff to assess or investigate.

Inspector ID #:	173

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 related to developing a process to ensure that staff are aware of the contents of the homes policies and comply with all policies, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10 s.53(1)1,4
Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
(1) Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
(4) Protocols for the referral of residents to specialized resources where required.

Findings:

1. Assessments that identify actual responsive behaviour demonstrated by an identified resident and triggers for that behaviour have not been completed. Plan of care for the resident states that the resident is verbally and physically aggressive. During interview with the staff and caregiver, their impression is that the resident's dementia causes the resident to misinterpret the actions of staff and the resident becomes resistive because the resident does not understand or comprehend what is happening when staff move too fast. This has been misinterpreted on the resident's plan of care as being aggressive.
2. Written approaches to care and strategies have not been developed to reduce incidents of responsive behaviours and increase success of care completion. Interventions on the plan of care are geared toward aggressive behaviours and do not address the issue of resisting care due to a resident being unable to understand the intent of the staff when they approach for care.
3. Reassessment of ongoing behaviours and revisions to the plan of care were not completed when interventions not effective to ensure safe care for an identified resident.
4. The responsive behaviours of an identified are ongoing and have impacted on the safe care delivery for the resident and staff. The resident's family has indicated several times that they are concerned with ongoing bruising and injury to the resident as a result of the resident's resistiveness to care. The home has not initiated referrals to any specialized resources in order to reduce these behaviours or develop successful interventions for care.

Inspector ID #:	173

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 related to developing a process to ensure that residents with responsive behaviours have written approaches to care that include assessment, reassessment and identification of behavioural triggers, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O. Reg. 79/10 s. 26(3)9, 10, 17.
A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
(9) Disease diagnosis.
(10)Health conditions, including allergies, pain, risk of falls and other special needs.
(17)Drugs and treatments.

Findings:

1. An identified resident's plan of care does not include monitoring of the respiratory status of the resident or give consideration to the diagnosis and recent infection sustained by the resident. The resident is prescribed medication to manage respiratory symptoms and oxygen if saturation level is below 90%. Given the residents changing condition, consideration of the resident's respiratory status would have been reasonable, but was not addressed in the plan of care.
2. No plan of care was developed related to the pain an identified resident was experiencing. The Resident Assessment Instrument (RAI) Assessment completed indicates moderate pain daily. The resident sustained a injury that would constitute regular pain medication.
3. The September 2010 Medication Administration record for an identified resident indicates that the resident was on routine medication and had prn (as necessary) medication available for coughing and oxygen saturation less than 90% on room air. The care plan does not indicate monitoring or interventions related to the residents respiratory status.

Inspector ID #:	173

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 related to developing a plan to ensure that all plans of care will be based on required assessments as indicated in the regulations, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O. Reg. 79/10 s. 52(2)
Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Findings:

A specified resident sustained an injury and was experiencing severe pain. No pain assessment or reassessment was completed to promote comfort.

1 No pain assessment was completed following injury to the specified resident to determine the effectiveness of the medication ordered for pain. Other treatments ordered were not completed that might have promoted increased comfort for the resident.
2 The RAI MDS assessment completed indicates a change from the previous assessment when it was recorded that the resident had no pain. The most recent assessment indicated that the resident was experiencing moderate pain daily. No further assessment or interventions to promote comfort were initiated.
3 A specified progress note indicates that the injury "looks bad, resident stated there was pain."
4 The specified resident returned from having a procedure. There were complaints of generalized discomfort and severe pain. Medication was given with little effect. No pain re-assessment was completed.

Inspector ID #:	192

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Aug 30/11 **Revised August 30, 2011 for the purpose of publication**
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).