



**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
prévus 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
Apr 10, 11, 19, 20, May 9, 15, 2012	2012_027192_0011	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

DEBORA SAVILLE (192)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers, Registered Practical Nurses, the Administrator and the Director of Care related to H-000182-12

During the course of the inspection, the inspector(s) Reviewed medical records, consultation notes, policy and procedure and observed the provision of care.

The following Inspection Protocols were used during this inspection:

Pain

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES



<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements
Specifically failed to comply with the following subsections:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. Previously issued as a VPC January 25, 2012.

The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. [O. Reg. 79/10, s. 30 (2)]

a) A specified resident was admitted to the home in 2012 with known wandering behaviour and was transferred to the secure unit in the home in 2012. There is no documentation of the resident presenting an elopement risk and no documented assessment of the resident to support transfer to a secure home area. Interview with the Director of Care and Administrator identified that the transfer was made as a result of staff concerns for the safety of the resident, related to wandering.

b) A specified resident was transferred to hospital in 2012 for assessment related to a change in health status. There is no documentation related to the residents return from hospital, interventions conducted as a result of this hospitalization or assessment on return from hospital where the resident was diagnosed and treated for an infection.

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management
Specifically failed to comply with the following subsections:

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. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. Previously issued as a VPC November 22, 2010.

The licensee failed to ensure that when the resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.
[r. 52]

a) A specified resident was admitted in 2012 with an analgesic for pain and arthritis. A pain assessment was conducted in 2012 that identified the resident did not have pain.

b) In 2012, documentation in the progress notes indicates that the resident was experiencing an increase in verbal and physical behaviours, had sustained a fall and complained of hip pain when attempting to stand. In 2012, there is documented complaint of pain in the lower back.

c) In 2012 the resident was diagnosed by the nurse practitioner with potential constipation/obstruction and was later sent to hospital where the resident was diagnosed with an infection.

d) On return from hospital the resident continued to complain of pain in the back and legs and one day did not sleep at all through the night due to pain. The analgesic was increased. Documentation from the physiotherapist in 2012 indicates the resident continued to have lower back pain.

e) Resident Assessment Protocols (RAP) completed in 2012 indicated that the resident was experiencing pain. No pain assessment using a clinically appropriate assessment instrument specifically designed for this purpose, was completed.

e) Interview with registered staff confirms that a pain assessment would be completed on return from hospital, with complaints of pain, and/or post fall. In addition, interview with the Director of Care confirms that a pain assessment would be completed with a change in analgesic, or any change in condition.

f) No pain assessment using a clinically appropriate assessment instrument specifically designed for this purpose, was completed for the specified resident post fall, with ongoing complaints of uncontrolled pain, with diagnosis of constipation and infection or with a change in analgesic.

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 when the resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs
Specifically failed to comply with the following subsections:**

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 :



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1. The licensee failed to ensure that drugs are administered to the resident in accordance with the directions for use specified by the prescriber. [r. 131. (2)]

At the time of admission in 2012 the physician ordered a 2 step tuberculosis (TB) test for a specified resident. It is documented in the resident's progress notes that they received a TB test #1 in the left forearm. The 2nd step TB test on two dates in 2012. The resident received the 2nd step TB test twice. The results of either step 2 test were not recorded.

WN #4: 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 subsections:

s. 3. (1) 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.

2. Every resident has the right to be protected from abuse.

3. Every resident has the right not to be neglected by the licensee or staff.

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.

5. Every resident has the right to live in a safe and clean environment.

6. Every resident has the right to exercise the rights of a citizen.

7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.

8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

9. Every resident has the right to have his or her participation in decision-making respected.

10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.

11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

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.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident has the right to participate fully in making any decision concerning any aspect of his or her care; including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters. [s. 3 (1) (11)(iii)]

a) A specified resident was transferred to the secure home area in 2012 following admission to the home in 2012.

b) A review of the progress notes demonstrates that the resident was admitted with a known history of wandering. There is documentation that the resident continued to wander on the home area from the time of admission and on one occasion was found on the third floor. There is no documentation prior to transfer that the resident presented an elopement risk.

c) The power of attorney for the specified resident indicates that they received a message that the resident had been transferred due to concerns of wandering.

d) There is no indication that the resident or the designate participated in decision making related to the transfer within the home.

Issued on this 29th day of May, 2012

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

Nehora Skwilt (192)