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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 16, 2013	2012_201167_0009	H-002272-12	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

MARILYN TONE (167)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 28, 2012, January 2, 2013.

During the course of the inspection, the inspector(s) spoke with The Administrator, the Director of Care, the Recreation and Support Services Coordinator, registered staff and personal support worker staff and the identified resident related to complaint Log H-002272-12.

During the course of the inspection, the inspector(s) conducted a review of the health file for the identified resident, reviewed relevant policies and procedures, observed care.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Falls Prevention

Personal Support Services

Recreation and Social Activities

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
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.) 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. 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 did not ensure that the home's policy related to Personal Assistive Service Devices (PASD)was complied with.

The home's policy related to Personal Assistive Service Devices (PASD) (LTCE-CNS-H-3- dated May 2012) directs staff to provide the following documentation when a PASD is to be used:.
The progress notes must include:
- PASD alternative trialed and evaluation of trial
- Activity of daily living (ADL) with which the PASD will assist the resident
- PASD assessment request and prescription and by whom
- Resident/Subsitute Decision Maker (SDM) discussion regarding the rational for the PASD
- Resident/SDM consent obtained
The care plan must include: - PASD and ADL with which the PASD will assist the resident
- Clear instructions on the application of the PASD
- Clear direction on the monitoring requirements.

1) The identified resident was noted to be using partial bed rails on either side of their bed when they was in bed.
2) Personal support worker and registered staff at the home who were interviewed confirm that the resident uses two bed rails when in bed to assist with mobility and to prevent them from rolling out of bed.
3) A review of the resident's health file revealed that there was no discussion with the resident's SDM (Substitute Decision Maker) related to the use of bed rails and that no consent was obtained.
4) A review of the document that the home refers to as the care plan revealed that the care plan did not identify the use of bed rails for the resident.
5) No assessment or alternatives tried were found for the use of the bed rails.
6) There was no clear instruction related to the application of the PASD or for any monitoring requirements.
7) Staff interviewed confirmed that the above documentation was not present for the resident. [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 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, procedure or protocol, that the plan, policy, procedure or protocol is complied with,, to be implemented voluntarily.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care provided clear direction to staff and others who provide direct care to the resident related to the resident's toileting needs.

- The document that the home refers to as the care plan for the identified resident related to toileting/continence that was in place prior to a change in their health condition indicates that they required extensive assistance and physical help with toileting to adjust clothes and provide peri-care. It also indicated that they used an incontinence product and to check for wetness every two to three hours and on rounds during the night. The goal identified on the care plan related to toileting stated - routine toileting to meet needs.
- Staff interviewed indicated that the resident was independent with toileting and only required assistance for peri-care and adjustment of clothing after a bowel movement. The staff interviewed indicated that when the resident required assistance they would ring the call bell in the bathroom. Both registered staff and personal support worker staff confirmed that the resident was deemed to be safe to be left in the bathroom without supervision prior to the change in their condition.
- The resident's care plan related to toileting/ continence does not provide clear direction related to the resident's level of independence with toileting or when assistance would be required. No routine toileting was identified on the care plan.

After a change in the resident's condition, the resident's care plan was updated to reflect their current needs. The toileting/continence care plan was revised to indicate: Provide total assistance. Requires two staff assistance with toileting. Staff will never leave the resident unattended on the toilet. Two staff will pivot transfer the resident to toilet. Two staff will help the resident to stand up from the toilet and provide peri-care. Under the continence care plan it indicated check for wetness every two to three hours and on rounds during the night.

- Personal support worker staff indicated during an interview that the resident was currently using a bed pan in bed for bladder continence due to change in their condition. The staff interviewed indicated that they ask the resident if they want to go to the toilet or use the bedpan. If the resident wished to go to the toilet, staff would take them. No toileting routine was identified for the resident, however staff indicated that they provide routine toileting/continence care for the resident. The care plan did not give clear direction to staff related to the resident's toileting needs. [s. 6. (1) (c)]

2. The licensee did not ensure that the following was documented: The provision of care set out in the plan of care.

- During a review of the resident care flow records for residents on an identifed home area on January 2, 2013, it was noted that there were no resident care flow records found in the flow sheet binders on the unit for the month of January 2013.
- During discussion with a personal support worker on that home area, it was found that the flow sheets had not been placed in the flow sheet binder for January 2013 and therefore had not been completed by staff for any of the residents on that home area from December 31, 2012 until January 2, 2013 when it was brought to the attention of staff. [s. 6. (9) 1.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the identified resident received a post-falls assessment using a clinically appropriate instrument after sustaining a fall.

1) The resident was noted to have sustained a fall and was subsequently transferred to hospital. No post-falls assessment was completed after this fall occurred. The registered staff member interviewed confirmed that a post-falls assessment should have been completed after the fall.
2)No post-falls assessment or any type of falls assessment was completed upon the resident's return from hospital. [s. 49. (2)]

Issued on this 16th day of January, 2013

[redacted]

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

Marilyn Lone