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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 7, 2012	2012_201167_0001	H-000621-12	Complaint

Licensee/Titulaire de permis

WATERDOWN LONG TERM CARE CENTRE INC.
689 YONGE STREET, MIDLAND, ON, L4R-2E1

Long-Term Care Home/Foyer de soins de longue durée

ALEXANDER PLACE
329 Parkside Drive, P. O. Box 50, Waterdown, ON, L0R-2H0

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 Complaint inspection.

This inspection was conducted on the following date(s): int inspection.October 24, 25, 2012

During the course of the inspection, the inspector(s) spoke with The Director of Care, the Administrator, nursing staff, the identified resident and their Power of Attorney related to Complaint Log # H-000621-12.

During the course of the inspection, the inspector(s) reviewed the health files for six identified residents, reviewed relevant policies and procedures and observed care.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

Pain

Personal Support Services

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. s.6(10)b The document that the home refers to as the care plan for resident # 001 was not updated to include interventions to prevent further trauma to their skin during positioning in bed.
a) Resident # 001 sustained a large skin tear during a repositioning activity.
b) The documentation in the resident's progress notes indicated that the plan to prevent further incidents included use of a specific intervention.
c) The document that the home refers to as the care plan for resident # 001 was not reviewed or revised to include the use of this specific intervention to assist in prevention of further skin tears.
d) Resident #001 sustained another skin tear approximately one month later during a repositioning activity. The nurse indicated in the progress notes that staff were taught to use a specific procedure when lifting or repositioning the resident in bed. The nurse also indicated that the care plan would be updated to include use of this intervention. It was noted that the care plan was updated to include this intervention.

The plan of care for resident # 001 was not reviewed and revised to include interventions for prevention of further skin tears during repositioning after the first skin tear occurred. [s. 6. (10) (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 the plan of care for residents are reviewed and revised when their care needs change., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines. O. Reg. 79/10, s. 26 (3).
2. Cognition ability. O. Reg. 79/10, s. 26 (3).
3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).
4. Vision. O. Reg. 79/10, s. 26 (3).
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).
6. Psychological well-being. O. Reg. 79/10, s. 26 (3).
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).
9. Disease diagnosis. O. Reg. 79/10, s. 26 (3).
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).
11. Seasonal risk relating to hot weather. O. Reg. 79/10, s. 26 (3).
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).
13. Nutritional status, including height, weight and any risks relating to nutrition care. O. Reg. 79/10, s. 26 (3).
14. Hydration status and any risks relating to hydration. O. Reg. 79/10, s. 26 (3).
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).
16. Activity patterns and pursuits. O. Reg. 79/10, s. 26 (3).
17. Drugs and treatments. O. Reg. 79/10, s. 26 (3).
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).
19. Safety risks. O. Reg. 79/10, s. 26 (3).
20. Nausea and vomiting. O. Reg. 79/10, s. 26 (3).
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).
22. Cultural, spiritual and religious preferences and age-related needs and preferences. O. Reg. 79/10, s. 26 (3).
23. Potential for discharge. O. Reg. 79/10, s.

Findings/Faits saillants :

1. The initial plan of care for resident # 001 was not at a minimum based on an interdisciplinary assessment of the resident with respect to: the level of assistance required for transferring, dressing, mobility , bathing, hygiene, bed mobility, bladder and bowel continence, the resident's activation needs, or other specialized treatments. Identification of these needs and interventions to address them were not added to the resident's plan of care based on the admission interdisciplinary assessment of the resident.
Resident # 001 was admitted to the home in December 2011.
- The plan of care related to cardiac issues was developed in March 2012.
- The plan of care related to the resident's special treatment was developed on September 2012.
- The plan of care related to continence was developed in March 2012.
- The plan of care related to transferring was initiated in April 2012
- The plan of care related to mobility was initiated in February 2012.
- The plan of care related to bathing was initiated in April 2012.
- The plan of care related to hygiene and grooming was initiated in March 2012.
- The plan of care related to bed mobility was initiated in March 2012.
- The plan of care related to urinary continence was initiated in September 2012.
- The plan of care related to bowel continence was initiated in September 2012. [s. 26. (3)]

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 initial plan of care for all residents is based at a minimum on an assessment of the resident's level of physical functioning and assistance required, activation needs and health conditions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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. The licensee did not ensure that any action taken with respect to a resident under a program, including interventions was documented.

a) It was noted on the Treatment Administration Record (TAR) for resident # 001 that prescribed treatments were not consistently signed as administered.
During the month of October 2012, the following treatments were prescribed:
- A treatment cream to the resident's scalp twice a day.
The TAR indicates that this treatment was not applied as prescribed on eight occasions between October 1 and 25, 2012.
- Resident # 001's dressing to an identified area was prescribed to be changed daily. The documentation on the TAR related to this dressing indicates that it was not changed nine times as prescribed from October 1-25, 2012.

b) It was noted that Resident # 002 had the following prescribed treatment.
- A treatment cream ordered October 1, 2012 to be applied twice a day (BID).
A review of the TAR for resident # 002 confirmed that from October 18-25, 2012 this treatment was not signed as administered four times.

c) It was noted that Resident # 003 had the following prescribed treatments:
- A treatment cream to be applied twice a day. A review of the TAR confirmed that there were 11 signatures missing for this treatment from October 1-25, 2012.
- A second treatment cream was ordered to be applied twice a day. A review of the TAR confirmed that there were 11 missed signatures for this treatment from October 1 -25, 2012.

d) It was noted that Resident # 004 had the following prescribed treatments:
- A treatment cream was to be applied twice a day to the affected area.
A review of the TAR confirmed that this treatment was not signed as administered 23 times from October 1-25, 2012.
- Change dressing to to an identified area every five days.
A review of the TAR confirmed that this dressing change was not signed as completed twice as scheduled between October 1-25, 2012.

Interviews with six registered staff members who were assigned to administer treatments on the shifts when the identified omission of signatures were identified, confirmed that these treatments were administered as prescribed and confirmed that they had forgotten to sign for them. [s. 30. (2)]

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 any action taken with respect to a resident related to treatment administration, including interventions are documented., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 25. Initial plan of care

Specifically failed to comply with the following:

s. 25. (1) Every licensee of a long-term care home shall ensure that,
(a) the assessments necessary to develop an initial plan of care under subsection 6 (6) of the Act are completed within 14 days of the resident's admission; and O. Reg. 79/10, s. 25 (1).
(b) the initial plan of care is developed within 21 days of the admission. O. Reg. 79/10, s. 25 (1).

Findings/Faits saillants :

1. The initial plan of care for resident # 001 was not developed within 21 days of their admission to the home.

a) Resident # 001 was admitted to the home in December 2011.
A 24 hour care plan was developed but the initial plan of care related to activities of daily living and continence was not developed within 21 days of the resident's admission to the home.
- The plan of care related to transferring was initiated in April 2012
- The plan of care related to mobility was initiated in February 2012.
- The plan of care related to bathing was initiated in April 2012.
- The plan of care related to hygiene and grooming was initiated in March 2012.
- The plan of care related to bed mobility was initiated in March 2012.
- The plan of care related to urinary continence was initiated in September 2012.
- The plan of care related to bowel continence was initiated in September 2012. [s. 25. (1) (b)]

Issued on this 7th day of December, 2012

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