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
Dec 10, 2015	2015_273580_0005	010072-15	Complaint

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

Waters Edge Care Community
401 WILLIAM STREET NORTH BAY ON P1A 1X5

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

VALA MONESTIME BELTER (580)

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): October 23, 26 and 27, 2015.

This Complaint inspection is related to complaints regarding dehydration, inadequate number of staff to assist residents during meals, the lack of provision of physiotherapy, improper skin, pain, continence and behaviour assessments, and the administration of medication to residents without consent.

The inspector reviewed policies, plans of care and other documentation within the home, conducted a daily walk through of the resident care areas, observed staff to resident interactions and the delivery of care and services to the residents.

During the course of the inspection, the inspector(s) spoke with residents, Substitute Decision Makers (SDMs), Personal Support Workers (PSWs), the Staffing Clerk, a Dietary Aide, the Nutrition Manager, Registered Practical Nurses (RPNs), Registered Nurses (RNs), the Assistant Director of Care (ADOC), the Director of Care (DOC), and the Administrator.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Medication
Pain
Personal Support Services
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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:
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. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident's right to, refuse consent to any treatment, care or services for which his or her consent is required by law, was respected and promoted.

In a complaint received by the Director, it was stated that the Substitute Decision Maker (SDM) with a Power of Attorney (POA) for resident #001, had declined to sign the consent for an anti-viral on admission of resident #001, yet the resident received a dose of the antiviral daily for three consecutive days.

The inspector reviewed the home’s Influenza Prevention and Management Program V6-140, which indicated that the home is to ensure that resident or SDM consent is obtained by registered staff for an anti-viral agent on the designated consent form, when the resident is admitted. The program also identified that this is a perpetual consent that needs to be obtained only once for the duration of the resident’s stay in the home.

The inspector reviewed the home’s Medication Incident Report which indicated that one oral dose of the antiviral was given daily for three consecutive days without the consent

of resident #001 or the resident’s SDM.

The inspector reviewed resident #001’s health care record which indicated that:
-the Consent to Administration of Immunization Agents, Mantoux and Antivirals form indicated that resident #001’s SDM had not given or signed consent for the anti-viral protocol and that the SDM had signed the form and written “refused” beside the Anti-viral protocol;
-the progress notes indicated that a message was left with the SDM informing them about the facility wide outbreak and that initiation of the antiviral was starting the following day;
-resident #001’s doctor indicated in the physician notes, that the home called to inform that resident #001 had received three doses of the antiviral, that the SDM had not given consent, that the SDM had been made aware of the incident;
-the progress notes indicated that Assistant Director of Care (ADOC) #203 reviewed the consent form for the resident, and confirmed that the consent form indicated that the SDM had refused consent for administration of the antiviral for any outbreak; and upon review of resident #001’s Medication Administration Record and the nursing notes, ADOC #203 confirmed that one dose of antiviral was administered daily for three consecutive days.

Director of Care #202 explained to the inspector that hard copies of consents including annual influenza consents are kept in a binder on each floor, that for the administration process for the antiviral, paper Medication Administration Records are printed out and placed in a binder, that in the case of resident #001, the registered staff had assumed that there were consents for all residents in the binder, however resident #001’s SDM has not given consent, that this lack of consent was missed by the registered staff, and that resident #001 received three doses of the antiviral without having given consent.[s.3.(1)11.ii.]

Issued on this 10th day of December, 2015

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

Original report signed by the inspector.