Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 25, 2020	2020_679687_0010	009803-20, 010624-20, 015087-20	Complaint

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM 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

LOVIRIZA CALUZA (687), KEARA CRONIN (759)

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): August 17 to 21, 2020.

The following complaints, that were submitted to the Director, were inspected during this Complaint (CO) Inspection.

- One intake related to resident to resident responsive behaviour and building maintenance, and
- Two intakes related to resident care.

A Critical Incident System (CIS) Inspection #2020_679687_0009 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Food Service Manager (FSM), Director of Environmental Services (DES), Physician, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Minimum Data Set-Resident Assessment Instrument (MDS-RAI) Coordinator, Receptionist, Personal Support Workers (PSWs), Dietary Aides (DAs), family members and residents.

The Inspector(s) also conducted a daily walk through of resident care areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed residents' health records, staffing schedules, internal investigations and the home's policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Infection Prevention and Control
Medication
Personal Support Services
Responsive Behaviours

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	Légende 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 O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee had failed to ensure that procedures and interventions were developed and implemented to assist residents who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

A complaint was submitted to the Director, which indicated an alleged resident to resident responsive behaviour incident which involved resident #002.

During a number of observations conducted by Inspector #687 with resident #002, the resident was observed with a specified mobility device in a specified area.

Inspector #687 reviewed resident #002's electronic progress notes which it indicated that resident #002 was noted with a specified behaviour in resident #007's specified location. The electronic progress notes further indicated that resident #007 had exhibited specific responsive behaviours towards resident #002 prior to staff members having the opportunity to intervene and to safely remove resident #002 away from the incident.

In a review of resident #002's electronic care plan in effect at that time, Inspector #687 did not identify any focus for resident #002's specified behaviour.

Inspector #687 reviewed the home's policy titled "Responsive Behaviours Management",

last revised October 2019, which indicated that “The nurse was to document in the individualized plan of care any measures to identify the level of risk or crisis triggers that would assist to promote a safe environment”.

During an interview with Personal Support Worker (PSW) #120, #123, Registered Practical Nurse (RPN) #118 and #119, they all stated that resident #002 had a specified medical symptom and was known for their specified behaviour in the specified areas in the unit.

Inspector #687 interviewed Registered Nurse (RN) #126 who responded to a responsive behaviour incident that occurred between resident #002 and #007 on a specified date. The RN stated that resident #002 was known for their specified behaviour for several years and that the resident was not aware of this behaviour. The RN further stated that they were surprised that resident #002's plan of care did not include a focus for their specified behaviour.

In an interview with the DOC, they stated that resident #002 was identified as a resident with a specified medical symptom who had a specified behaviour in the unit. The DOC recognized that a responsive behaviour incident had occurred between resident #002 and #007, and that resident #002 was at risk for harm. The DOC stated that resident #002's specified behaviour at that time was an opportunity for the registered staff to review the resident's plan of care but it was not reviewed and updated. [s. 55. (a)]

Issued on this 27th day of August, 2020

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

Original report signed by the inspector.