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

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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 8, 2014	2014_323130_0022	H-001099-14	Resident Quality Inspection

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

GILLIAN TRACEY (130), IRENE PASEL (510), KELLY HAYES (583)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 27, 28, 29, 30, November 4, 5, 6 and 7, 2014

Please note: The following critical incident inspections were conducted concurrently with this RQI: H-000594-14, H-000782-14 and H-001033-14

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Food Services Manager (FSS), Registered Dietitian (RD), Corporate Registered Dietitian, Environmental Services Manager (ESM), Program and Support Services Manager, President of Residents' Council, Registered staff, personal care providers (PCPs), residents and families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

12 WN(s)
5 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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

A) During the initial tour of the home on October 27, 2014, it was observed that a number of walls in resident rooms, tub rooms, spas, hallways and common areas were heavily scuffed or damaged with exposed drywall. Room #122 was noted to have extensive wall damage, with exposed drywall and the linoleum flooring was torn underneath all four wheels of the mechanical bed. Rooms, #307, #316 and #339 had damaged walls, with holes or gauges observed. The linoleum flooring in the Oakville Spa, was torn where the linoleum joined the tile in the shower. The walls in the Spa were heavily scuffed. The walls in the Oakville Jacuzzi Room were heavily scuffed and contained exposed drywall. The walls in the Sheridan Spa and Jacuzzi rooms were heavily scuffed and had areas that showed evidence of repatching which had not been repainted. A hand rail in the hallway of the Trafalgar home area was observed to be wrapped with duct tape. Wall damage in resident rooms was prevalent throughout all home areas. The ESM was interviewed and confirmed the disrepair. (Inspector #130)

B) During the initial tour on October 27, 2014, the walls and doors were observed to be scuffed and chipped throughout the Palermo, Appleby and Bronte home areas. In the Palermo shower room, the walls were chipped with a repair underway around the tap but the area was not sanded or painted. The counter in the Jacuzzi room was chipped. In the hallway outside room #363, the corner portion of the upper wall rail was missing. On the Appleby home area the tub room counter was chipped and the baseboard was pulling away from the wall under the sink. The corner of the lower wall rail was broken (across from entrance to nursing station) and the upper guard rail was broken at the door to the Spa. The lock on the nursing station door was broken and removed by maintenance on October 27, 2014. It was not replaced until October 29, 2014. On the Bronte home area, the wallboard was damaged at the entry to the Spa room. (Inspector #510) [s. 15. (2) (c)]

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 home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A) The home's Resident Abuse Policy, RCA-LTCE-E-02 RCAM-IV-15, indicated: Abuse reporting was mandatory; all staff members were required to report any abuse or allegation of abuse immediately to the Administrator/General Manger, Director of Care/Resident Services Manager or designate. The person receiving the report was to report the allegation to the provincial Ministry of Health and Long Term Care/Regional Authority; A staff member who was receiving a report of or observing anyone abusing a resident would assess the resident immediately, Registered Staff would complete a resident assessment; document all events related to a reported/alleged abuse in the resident chart; ensure all physical assessments/examinations were recorded with clear descriptions and great detail and all entries were signed, dated, with the time of the documentation. The Resident Incident Report form (either electronic in Point Click Care or paper) must also be completed.

B) On an identified date in 2014, resident #137 reported to Registered staff that an identified PCP was rough with them during care, was rude, yelled at them and aimed a pillow at them when they were alone. The Registered staff was interviewed and confirmed the resident had reported the incident at the end of their shift, they had documented the allegation of rough treatment, but had not assessed the resident for injury and had not immediately notified the Administrator as per the home's policy. This information was confirmed by the DOC and Administrator. (Inspector #130)

C) On an identified date in 2014, the home reported an incident of alleged staff to resident abuse, which had occurred on a specified date in 2014. The home confirmed the incident was not immediately reported to the Director, as required. (Inspector #130) [s. 20. (1)]

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 written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (3) If a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that,
(a) the device is used in accordance with any requirements provided for in the regulations; 2007, c. 8, s. 31 (3).
(b) the resident is monitored while restrained, in accordance with the requirements provided for in the regulations; 2007, c. 8, s. 31 (3).
(c) the resident is released and repositioned, from time to time, while restrained, in accordance with the requirements provided for in the regulations; 2007, c. 8, s. 31 (3).
(d) the resident's condition is reassessed and the effectiveness of the restraining evaluated, in accordance with the requirements provided for in the regulations; 2007, c. 8, s. 31 (3).
(e) the resident is restrained only for as long as is necessary to address the risk referred to in paragraph 1 of subsection (2); 2007, c. 8, s. 31 (3).
(f) the method of restraining used is discontinued if, as a result of the reassessment of the resident's condition, one of the following is identified that would address the risk referred to in paragraph 1 of subsection (2):
(i) an alternative to restraining, or
(ii) a less restrictive method of restraining that would be reasonable, in light of the resident's physical and mental condition and personal history; 2007, c. 8, s. 31 (3).
(g) any other requirements provided for in the regulations are satisfied. 2007, c. 8, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident was being restrained by a physical device under subsection (1), that the device was used in accordance with any requirements provided for in the regulations.

A) The Pelvic Support Belt Installation And User's Instructions indicated: When properly adjusted and the belt tightened, it should fit snug so that the user's pelvis was secure. On an identified date in 2014, resident #001 was observed in their wheelchair with a front fastening seat belt applied loosely; allowing a five finger spread between the resident's abdomen and the device. Staff interviewed confirmed the seat belt was too loose. Staff did not apply the physical device in accordance with the manufacturer's instructions. (Inspector #130) [s. 31. (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 when a resident is being restrained by a physical device under subsection (1), that the device is used in accordance with any requirements provided for in the regulations, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a response was provided in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

A) A review of the Residents' Council meeting minutes and Residents' Council recommendation/concerns Response form was completed from January 2014 to September 2014. Responses were not provided in writing within 10 days of receiving Residents' Council advice after Council meetings in January, February, March, April, and May 2014. In an interview with the DOC on November 5, 2014 and the Program and Support Services Manager on November 6, 2014, it was verified that the licensee did not respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations. (Inspector #583) [s. 57. (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 a response is provided in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee has failed to comply with the conditions to which the licence was subject. 2007, c. 8, s. 101. (4).

1. The licensee did not comply with the conditions to which the licensee was subject as outlined in section 4.1 Schedule C of the Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health System Integration Act, 2006, which reads, "The Health Service provider shall use the funding allocated for an envelope for the use set out in applicable policy". The Long-Term Care Homes Nursing and Personal (NPC) Envelope Section 1. b) reads, "direct nursing and personal care includes the following activities: assistance with the activities of daily living including personal hygiene, services, administration of medication, and nursing care."

A) On November 3, 2014, PCPs (nursing staff) were observed completing laundry duties (delivering personal laundry to resident rooms). Staff verified that delivering personal laundry to residents is part of their routine duties. The Administrator confirmed the PCPs were paid from NPC Funds. (Inspector #130) [s. 101. (4)]

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 the conditions to which the licence is subject as outlined in section 4.1 Schedule C of the Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health System Integration Act, 2006, which reads, "The Health Service provider shall use the funding allocated for an envelope for the use set out in applicable policy". The Long-Term Care Homes Nursing and Personal (NPC) Envelope Section 1. b) reads, "direct nursing and personal care includes the following activities: assistance with the activities of daily living including personal hygiene, services, administration of medication, and nursing care", is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee did not ensure that the home was a safe and secure environment for its residents. 2007, c. 8, s. 5.

A) During the initial tour of the home on October 27, 2014, the door marked "Clinic" on level three was found to be unlocked. A bottle of isopropyl alcohol was found in the unlocked cupboard in the clinic. The DOC confirmed it was the home's expectation that isopropyl alcohol not be left in areas available to residents. The home did not ensure the environment was safe for residents. (Inspector #510)

B) A bottle of isopropyl alcohol was also observed in the shared bathroom of an identified resident on October 28, 2014. Staff confirmed there were cognitively impaired residents residing on the unit. (Inspector #130) [s. 5.]

WN #7: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the written plan of care for each resident was based on an assessment of the resident's needs.

A) Resident #116 was observed having difficulty picking up food with their utensil and spilling food off their plate during breakfast service on an observed date in 2014. In an interview with resident #116 during the breakfast service they shared they could not see the toast, cottage cheese or three pieces of large colorful fruit on the plate due to poor vision. Resident #116 was not able to identify the objects on their plate and was wearing their glasses. The visual function assessment completed on a specified date in 2014, indicated resident #116 was moderately impaired and could identify objects. In an interview with the Restorative Care Coordinator/RAI backup it was confirmed that the visual plan of care was not based on the assessed needs of resident #116. (Inspector #583) [s. 6. (2)]

WN #8: 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 any plan, policy, protocol, procedure, strategy or system, was complied with.

A) The Home's document titled Personal Clothing – Missing, NESM-E-01.01, issued February 2011, identified as page 27 of the Laundry Services Guidebook, directed that a person receiving the report of lost clothing would document all information on the missing clothing report form. Resident #121 reported that they had lost an article of clothing in the past six months. Staff confirmed knowledge of this and reported the substitute decision maker (SDM) had advised that the resident had given the item to another resident. Review of the missing clothing log revealed there were no reports of missing clothing for the year 2014. The DOC confirmed the home's policy was not complied with. (Inspector #510) [s. 8. (1) (b)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A) On an identified date in 2014, cognitively alert resident #137 reported to Registered staff that a PCP had been rough with them during care and that they felt pain to an identified area after the care. The resident was interviewed during this inspection and accurately reiterated the allegation to the Inspector. The Administrator and the DOC had conducted an internal investigation regarding the allegation and confirmed disciplinary action was taken against the accused staff. The PCP is no longer employed by the home.(Inspector #130) [s. 19. (1)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. Then licensee has failed to ensure that resident #138 received fingernail care.

A) On an identified date in 2014, resident #138's nails were observed to be long, uneven with dirt under all their fingernails. A review of the daily flow sheet documentation showed that resident #138 received a shower on an observed date in 2014, as per their planned bathing schedule. The following day, Registered staff observed resident #138 per inspector #583's request and confirmed that the resident's nails were long, uneven and dirty. (Inspector #583) [s. 35. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a dining and snack service that included providing residents with eating aids and encouragement required to safely eat and drink as comfortably and independently as possible.

A) During lunch service on November 4, 2014 and breakfast service on November 5, 2014, resident #116 was observed wearing eye glasses and eating at a table where no assistance was being provided by staff. Resident #116 was observed having difficulty picking up food with their utensils and food was spilling off the plate onto the table. On November 5, 2014, at breakfast resident #116 had toast, cottage cheese and three large pieces of colorful fruit on their plate. In an interview with the resident, they stated they could not see or locate any of the food items on their plate due to their poor vision. In an interview with the Registered staff it was verified that resident #116 was having difficulty eating due to visual impairment. It was confirmed with the RD on November 5, 2014, that resident #116 did not have an order for interventions such as a colored plate or rimmed plated nor had an assessment been completed. It was verified with the RD that an assessment was required to identify which eating aids would assist resident #116 to safely eat and drink as comfortably and independently as possible. (Inspector #583) [s. 73. (1) 9.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart?

A) At 1400 hours on November 5, 2014, a review of the drug destruction process was completed with the DOC. The DOC demonstrated that the discarded controlled substances were stored in a locked drawer in the locked medication room on Palermo home area. It was observed that the discarded controlled substances were not stored in a double locked stationary cupboard. The DOC confirmed that the controlled substances were not stored in a double locked stationary cupboard in the locked medication room. (Inspector #510) [s. 129. (1) (b)]

Issued on this 8th day of December, 2014

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

Original report signed by the inspector.