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
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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
Sep 30, 2013	2013_210169_0025	H-001048-12	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

YVONNE WALTON (169)

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): September 16, 17, 18, 19, 24, 25, 2013

Three critical incidents were inspected simultaneously.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care, nursing staff, residents and families

During the course of the inspection, the inspector(s) observed the care provided, reviewed clinical records, policies and procedure and administrative documentation.

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

Dignity, Choice and Privacy

Falls Prevention

Pain

Skin and Wound Care

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.)	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. 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has not fully respected and promoted Resident #1 right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity.

Resident #1 stated they are not taken to the washroom at times when they request. The resident was interviewed and stated staff make them feel like their needs are not important. They make the resident feel like their needs don't count. The resident stated they don't tell staff when they need care now.

Staff tell Resident #1 when they have to go to bed as the staff need to complete their care before they go off their shift. The resident requested to go to bed at a certain time, however this was not respected and Resident #1 was expected to go to bed at a time that met the needs of the staff.
They do not respect her right to choose their bedtime and allow them to feel respected in making choices about their care decisions. This was verified by the nursing staff. [s. 3. (1) 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 that ensures every resident is treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. Staff did not use safe transferring and positioning techniques when assisting Resident #2. In 2012, Resident #2 was being wheeled in their wheelchair and sustained an injury. The staff did not use a safe transferring technique for Resident #2 while transporting them in their wheelchair. This was confirmed by the resident and the administrator. [s. 36.]

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 that ensures staff use safe transferring and positioning devices or techniques when assisting residents., to be implemented voluntarily.

Issued on this 30th day of September, 2013

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

Yvonne Walton