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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 4, 2013	2013_214146_0065	H-000553-13	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 WILLOWGROVE
1217 Old Mohawk Road, ANCASTER, ON, L9K-1P6

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

BARBARA NAYKALYK-HUNT (146)

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): November 29, 2013.

Inspector Roseanne Western 508 was in attendance.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Associate Director of Care (ADOC), registered staff, Personal Support Workers (PSW's) and residents.

During the course of the inspection, the inspector(s) reviewed the policies related to falls management and restraint use, resident health records, incident reports and the home's internal investigation notes

The following Inspection Protocols were used during this inspection:
Falls Prevention

Minimizing of Restraining

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.) 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee did not ensure that, when the resident was reassessed and the plan of care reviewed and revised because care set out in the plan was not effective, that different approaches were considered in the revision of the plan of care.
Resident #001's plan of care indicated the resident was at high risk of falls. The resident fell six times in a five week period. The sixth fall resulted in a serious injury. Two of resident #001's falls occurred when the resident attempted to get out of bed with bed rails raised. No different approaches, such as lowering the bed, the rails or using a fall mat were considered in the plan of care after either fall. Bed rails were in the raised position on the current plan of care reviewed during this inspection.
Resident #001's record indicated that on multiple occasions the resident undid the seat belt on the wheelchair, resulting in two falls. There were no different approaches considered to prevent falls as a result of undoing the seat belt, such as a seat belt alarm or an alternate type of restraint. On the date of this inspection, staff indicated that the resident continues to undo the front fastening seat belt and no seat belt alarm is in place. This information was confirmed by observation, the health record, PSW's and the ADOC. [s. 6. (11) (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 when a resident is reassessed and the plan of care reviewed and revised, if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, 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. The licensee did not ensure that staff used safe transferring and positioning devices or techniques when assisting resident #001.
In August 2013, resident #001 was transferred by mechanical lift from a wheelchair and placed into a shower chair in preparation to be transferred into the shower. Resident #001 was left unattended and unsupervised in the shower chair. Resident #001 fell out of the shower chair and sustained a serious injury. This information was confirmed by the home's internal investigation notes, the health record and the ADOC. [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 to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the following rights of residents were fully respected and promoted: 8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
In August 2013, resident #001 was transferred via mechanical lift from a wheelchair to a shower chair and undressed in preparation for a shower while another resident was toileted in the same bathroom. Two PSW's were in attendance and both confirmed in interviews with the home's managers that they knew that they should not have residents in the bathroom together. The ADOC confirmed that this practice was not acceptable and did not ensure resident privacy. This information was confirmed by the health record, the home's internal investigation notes and the ADOC. [s. 3. (1) 8.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions.
In November 2013, resident #001 was observed sitting in the lounge in a wheelchair. A front fastening seat belt was applied, fastened and sitting loosely on the resident's lap rather than the suggested two finger breadth application. The ADOC, who was in attendance tightened the seat belt in accordance with manufacturer's instructions. This information was confirmed by observation. [s. 110. (1) 1.]

Issued on this 4th day of December, 2013

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

Barb Naykaluk-Hunt