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
Jun 30, 2014	2014_247508_0017	H-000815-13/H-000003-14	Critical Incident System

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

ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 17, 18, 19, 20, 23, 2014

This inspection was conducted simultaneously with inspections #H-000807-13, H-000897-13, H-000435-14

During the course of the inspection, the inspector(s) spoke with the Administrator, Directors of Care (DOC), Assistant Director of Care (ADOC), Registered staff, Personal Support Workers (PSW), residents and family members.

During the course of the inspection, the inspector(s) toured the facility, interviewed residents and staff, reviewed clinical records, relevant policies and procedures, complaint log, missing laundry forms, and observed care and meal service

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Resident #106 was assessed as a high risk for falls after the resident fell and sustained a fracture in November, 2013. It was observed by the compliance inspector that the resident had a "fall mat" in their room. Staff interviewed in June, 2014, indicated that they refer to the resident's plan of care for direction, however, directions on the use of a "fall mat" were not identified in the resident's plan of care.

It was confirmed by the Director of Care that the use of the "fall mat" for resident #106 should have been identified on the resident's plan of care. [s. 6. (1) (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 the plan of care sets out clear directions to staff and others who provide direct care to residents including resident #106, to be implemented voluntarily.

WN #2: 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 policies instituted or otherwise put in place were complied with.

a) The home's policy LTCE-CNS-G-17, titled, Responsive Behaviours, under the specific guidelines section, directs staff to administer a psychotropic drug or a 'when necessary' (PRN) medication as ordered and evaluate for possible reduced dosage or discontinuation. Registered Nurses only may assess and determine the need to administer PRN medication.

Resident #106 was ordered a psychotropic medication PRN for agitation. The resident's clinical record indicated that on four occasions in April, and four occasions in June, 2014, Registered Practical Nurses (RPN) administered this medication for agitation without an assessment conducted by a Registered Nurse. During an interview with the Director of Care, it was confirmed that staff did not following the home's policy for psychotropic PRN medication administration.

b) The home's policy RCA-LTCE-D-03, titled, Documentation-General Guidelines, directs staff to document only those observations and actions of which you have direct knowledge and ensure documentation is an accurate account of what was heard, seen, done, talked about, care given, etc. Staff confirmed that they had documented that they had removed the restraint, changed the resident's position and checked the resident for safety before this was done.

Resident #106 was a restraint while up in their wheelchair. During a review of the resident's clinical records, it was noted that on June 19, 2014, personal support workers and registered staff had documented at 1150 hours on the Restraint Monitoring Record that they had removed the restraint, changed the resident's position and checked the resident for safety at 1200, 1300, and 1400 hours. A review of resident #108's Restraint Monitoring Record indicated that the staff also documented that they had removed the restraint, changed the resident's position and checked the resident for safety at 1200, 1300, and 1400 hours. An interview with the Director of Care confirmed that the staff documented care that had not yet been provided. [s. 8. (1) (a),s. 8. (1) (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 policies instituted or otherwise put in place are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee did not ensure that staff were using all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

It was observed on June 18, 2014, on the second floor lounge area that two residents sitting in their wheelchairs had front fastening seat belts that were laying loosely in their laps, approximately six inches from the residents abdomen. According to manufacturers' instructions, the belt should be kept tightened at adjustment straps during daily use to ensure correct pad placement.

It was confirmed by staff that the seat belts were not fastened according to manufacturers' instructions and staff immediately tightened the seat belts. [s. 23.]

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 using all equipment, supplies, devices, assistive aids, and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

Issued on this 24th day of July, 2014

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