



Ministry of Health and Long-Term Care

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Inspection Report under the LTC Homes Act, 2007 ☒ Public Copy Licensee Copy		Rapport d'inspection prévue de la Loi de 2007 les foyers de soins de longue durée Copie du Titulaire ☒ Copie de la Publique	
Date(s) of Inspection/Date de l'inspection August 17, 2010	Inspection No/ d'inspection 2010-168-2861- 16Aug17829	Type of Inspection/Genre d'inspection Other – Critical Incident H-00832	
Licensee/Titulaire Waterdown Long-Term Care Centre Inc. 689 Yonge Street Midland ON L4R 2E1			
Long-Term Care Home/Foyer de soins de longue durée Alexander Place 329 Parkside Drive P.O. Box 50 Waterdown ON L0R 2H0			
Name of Inspector(s)/Nom de l'inspecteur(s) Lisa Vink			

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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 suivant constituer un avis d'écrit de l'exigences prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct an Other – Critical Incident Inspection

The inspection was conducted by Lisa Vink, #168.

The inspection occurred on August 17, 2010.

During the course of the inspection, the inspector spoke with:
The Administrator, Nursing Manager/Staff Educator and front line nursing staff

The following Inspection Protocols were used during this inspection:
Fall Prevention
Pain

2 Findings of Non-Compliance were found during this inspection. The following action was taken:
2 WN
1 VPC

NON-COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Plan of correction/Plan de redressement
DR – Director Referral/Régisseur envoi
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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 suivant constitue un avis d'écrit de l'exigences prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN#1: The Licensee has failed to comply with: LTCHA, 2007, S.O. 2007, c.8, s6(1)(c)

The licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

Findings:

1. The specified resident was recently assessed to require a mobility device. The need of this mobility device and the staff intervention associated were not included on the document staff refers to as the Care Plan. The resident recently fell, at which time care needs changed from being independent with some activities of daily living to requiring total staff assistance with toileting and transferring. The Care Plan was not updated to reflect these changes in the resident's care needs.
2. The residents Care Plan has not been updated to reflect changing need related to pain management since the fall.

VPC – Pursuant to LTCHA, 2007, S.O. 2007, c. 8, s.152(2) the licensee is hereby requested to prepare a written plan or correction for achieving compliance with s. 6(1)(c) in respect to ensuring that the resident plan of care sets out clear direction to staff providing care. This is plan is voluntary.

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WN#2: The Licensee has failed to comply with: O. Reg. 79/10, s. 52(2)

The licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Findings:

1. The specified resident was ordered a narcotic, as needed, post fall, to manage symptoms of pain and this medication was increased to three times a day two days later; however no pain assessment instrument was utilized to assess the resident at this time.

Inspector ID#: 168

Signature of Licensee of Designated Representative
Signature du Titulaire du représentant désigné

Signature of Health System Accountability and Performance Division
representative/Signature du (de la) représentant(e) de la Division de la
responsabilisation et de la performance du système de santé.

Title:

Date:

October 12-2010 *Chadwick*
Date of Report (if different from date(s) of inspection).