Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 13, 2020	2020_824765_0003	024305-19	Critical Incident System

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

Long-Term Care Home/Foyer de soins de longue durée

Waters Edge Care Community
401 William Street NORTH BAY ON P1A 1X5

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

HILARY ROCK (765)

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): February 4 - 7, 2020.

**The following intake was completed in this Critical Incident System Inspection:
One intake related to falls.**

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The inspector(s) also observed resident care areas, the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, internal investigation documents, policies and procedures.

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

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

- **1 WN(s)**
- **1 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	Légende 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident System (CIS) report was submitted to the Director regarding a fall resident #001 had which caused a significant change to the resident's health status.

Inspector #765 reviewed resident #001's care plan, which indicated that they had fall interventions consisting of three different specified devices.

During observations on a specified date, Inspector #765 found resident #001 unsupervised in a specified area. Their two specified devices were not implemented at the time of observation. On a different specified date, Inspector #765 observed resident #001's other specified device not implemented; Registered Nurse (RN) #104 confirmed and corrected.

Inspector #765 reviewed "Falls Prevention and Management" Policy # VII-G-30.10 last revised April 2019, that indicated Personal Support Workers (PSW) were to utilize fall prevention interventions identified in the resident's plan of care.

During separate interviews with Inspector #765; PSW #101, PSW #105, Registered Practical Nurse (RPN) #102, RPN #103, RN #104 and Director of Care (DOC) #108 all indicated that resident #001 was to have all three specified devices implemented. RPN #102 and RN #104 mentioned to Inspector #765 in separate interviews that resident #001 should have had their specified devices implemented at time of observations.

In an interview, DOC #108 confirmed to Inspector #765 that resident #001 should have had their three specified devices implemented. [s. 6. (7)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed.

A CIS report was submitted to the Director regarding a fall resident #001 which caused a significant change to the resident's health status.

Inspector #765 reviewed resident #001's care plan at the time of their fall which indicated specified interventions. Inspector #765 reviewed a progress note on Point Click Care from just under three months prior to the fall, that indicated that resident #001 might have needed a specified device.

Inspector #765 reviewed "Falls Prevention and Management" Policy # VII-G-30.10 last revised April 2019, that indicated that each member of the interprofessional team would discuss appropriate interventions with the interprofessional care team and document all interventions added to the plan of care, implemented, and evaluated on a quarterly basis. Inspector #765 also reviewed "Code Purple – Post Fall Huddle Process" which advised staff they were to review the current interventions to determine if the interventions were still applicable and make changes as necessary to ensure care plan was current.

In an interview, PSW #105 stated to Inspector #765 that a specified shift would document a hand written report of what they were doing and what helped. PSW #105 indicated that it was written on the sheet that they required the specified device for resident #001 as the current interventions were unsuccessful. PSW #105 stated that it was not too long after the specified shift indicated that resident #001 needed the specified device on the written report that the resident fell and had a significant change.

During an interview, RPN #103 mentioned to Inspector #765 that resident #001 had falls that were on a specified shift in a specified location. RPN #103 stated that resident #001 would have benefitted from a specified device; they indicated this in their progress note just under three months prior to the fall. In regards to the progress note, RPN #103 mentioned that they never followed up as they hoped other shifts would have brought it up as well.

In an interview, RN #104 mentioned to Inspector #765 that resident #001 did self transfer at the specified time of day. While looking through the progress notes, RN #104 mentioned that there was nothing added regarding the trial of the specified device or any other follow up. RN #104 confirmed that resident #001 would have benefitted from the specified device.

DOC #108 confirmed to Inspector #765 that there was nothing in the progress notes regarding the trial of the specified device or any other follow up. DOC #108 mentioned they could not see any interventions added in the falls section in their care plan after resident #001's fall in three months prior. DOC #108 mentioned that the specified device would have been beneficial for resident #001. [s. 6. (10) (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 the care set out in the plan of care is provided to residents as specified in the plan as well that residents are reassessed and the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change, to be implemented voluntarily.

Issued on this 24th day of February, 2020

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

Original report signed by the inspector.