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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 5, 2017	2017_538144_0037	019114-17	Resident Quality Inspection

Licensee/Titulaire de permis

QCC CORP
3942 West Graham Place LONDON ON N6P 1G3

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

WATFORD QUALITY CARE CENTRE
344 VICTORIA STREET P. O. BOX400 WATFORD ON N0M 2S0

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

CAROLEE MILLINER (144), NANCY SINCLAIR (537)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): August 25, 27, 28, 29, 2017.

The following intakes were completed within the RQI:
Log 011014-17 - Complaint related to nursing and personal care, availability of supplies, staffing and water temperatures
Log 015888-17 - Critical Incident 2652-000004-17 related to transferring and positioning

During the course of the inspection, the inspector(s) spoke with 20 + residents, three family members, a representative from the Resident and Family Councils, the Administrator, Director of Care, the Nutritional Manager, two Registered Nurses, four Registered Practical Nurses, nine Personal Support Workers, one Dietary Aide, one Housekeeping Aide and one maintenance personnel.

During the course of the inspection, Inspectors toured the home, observed medication administration and recreation activities, reviewed resident clinical records, relevant policies and procedures, observed provision of resident care, resident-staff interactions, posting of required information and general cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Residents' Council
Skin and Wound Care
Sufficient Staffing

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

2 WN(s)
2 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	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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that outcomes of the care set out in the plan of care are documented.

Record review for one resident indicated the implementation of a specific treatment ordered by the Registered Dietician (RD).

The electronic medication administration record (eMAR) for the resident was reviewed and determined that the treatment was administered as ordered during the time frame of review. There were no documented records of the supplement consumed by the resident 7 out of 30 times or 23 per cent of the time.

On another identified date, the record review for the resident indicated implementation of a second treatment by the RD.

The eMAR record was reviewed for the second treatment and determined that the treatment was administered as ordered during the date of review. There were no documented records of the supplement consumed by the resident 5 out of 19 times or 26 per cent of the time.

The home's policy related to the treatment ordered by the RD included the RD must follow the progress of the resident receiving treatment and monitor acceptance of the product and effectiveness of its use.

One Registered Nurse (RN) stated that when a treatment was ordered for a resident by the RD or physician the registered staff would process the order in the electronic eMAR, record in the eMAR when the treatment was administered, and then would be expected

to record the amount of treatment taken by the resident.

The Director of Care (DOC) stated that the registered staff who administered a treatment ordered specifically by the RD or physician, would administer the treatment as per the order, sign for the administration in the eMAR, and record the amount of the treatment taken in POC. The DOC stated the RD would then be able to review and assess the effectiveness of the intervention. The DOC stated that if the amount of treatment consumed by the resident or the refusal of the treatment by the resident were not recorded, the RD would not be able to assess the effectiveness of the intervention.

The Nutrition Manager stated during interview that the RD would review the documentation completed by the registered staff to evaluate the effectiveness of the interventions ordered for the resident.

The DOC stated that it was an expectation that the outcomes of the care set out in the plan of care for a resident, such as the amount of treatment accepted by a resident, would be documented.

The severity of this non-compliance is minimal harm/risk or potential for actual harm/risk. The scope is widespread. There was no history of related non-compliance with this section of the legislation. [s. 6. (9) 2.]

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 o ensure that outcomes of the care set out in the plan of care are documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Several resident clinical records were reviewed with one RN in response to an allegation that resident baths were not being provided by the home.

Eleven resident clinical records did not include information that indicated baths were provided as outlined in the resident's care plans on one identified date.

One RN said that on the identified date, the morning bath aide shift was short staffed and unable to be replaced through the homes' call-in procedure.

One RN and the Inspector reviewed the nursing unit desk calendar for one identified date. The calender indicated the following:
- morning bath aide shift was not replaced
- afternoon bath aide shift was not extended to assist with completing the scheduled resident baths
- an additional PSW was not scheduled the following day to assist with completing resident baths
- resident baths were not rescheduled to an alternate date.

Two RN's acknowledged that when the morning bath aide shift could not be replaced, the home's protocol included extending the hours of the afternoon bath aide shift and failing that, initiating the call-in procedure to schedule an additional PSW the following day to assist with completing the missed resident baths.

The Administrator, one RN and the Inspector reviewed the PSW schedule on an

identified date. The schedule indicated the morning bath aide shift was not replaced and that an additional PSW was not scheduled the following day to assist with completing the missed resident baths.

The Administrator said that the home’s bath protocol as explained to the Inspector by the above two RN's was the procedure that should have been followed to ensure that the above resident baths were provided.

The severity of this non-compliance is minimal harm/risk or potential for actual harm/risk. The scope is widespread. There was no history of related non-compliance with this section of the regulations. [s. 33. (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 residents were bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

Issued on this 11th day of September, 2017

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

Original report signed by the inspector.