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
Mar 26, 2018	2018_538144_0003	002425-18	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 WATFORD ON N0M 2S0

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

CAROLEE MILLINER (144), NANCY SINCLAIR (537), TERRI DALY (115)

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): February 26, 27, 28, March 1,5, 6, 7, 8 and 9, 2018

**The following intake was completed within the RQI:
022395-17 -2652-000005-17 - Critical Incident related to falls prevention.**

During the course of the inspection, the inspector(s) spoke with more than 20 residents, the Residents' Council President, Family Council Representative, family members, the Administrator, Director of Care, Nutrition Manager, Program Director, five Registered Nurses, five Registered Practical Nurses, nine Personal Support Workers, one maintenance personnel and one Laundry Aide.

The inspector(s) conducted a tour of the home, observed medication administration, medication storage areas, recreational activities, reviewed relevant clinical records, reviewed relevant policies and procedures, the provision of resident care, resident-staff interactions, posting of required information and observed general maintenance, cleanliness and condition of the home.

**The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Skin and Wound Care**

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

4 WN(s)
4 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. 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: a resident had the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

On one identified date, the Inspector entered the nurse's desk area and observed that there were no personnel in the area and that the desk top computer had been left open revealing Point Click Care (PCC) clinical record information for one resident.

The nurse's desk area was an open concept facing the resident lounge and was not secured with a door. The nurse's desk area was entered by the inspector from the right side of the corridor that led to the resident lounge. The computer that housed the PCC software program was stored on the top of the desk at the nurse's station. Three residents were observed walking in the corridor toward the resident lounge and several residents observed seated in the lounge.

Two RPN's told the Inspector that the home's practice was for registered staff to log out of PCC when they left the nurses desk area.

The DOC shared that in order to maintain the confidentiality of resident electronic health records, registered staff were required to log out of the PCC computer system when they left the desk area.

The licensee failed to ensure that a residents' personal health information was kept confidential. [s. 3. (1) 11. iv.]

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 a resident had the right to have his or her personal health information kept confidential in accordance and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident had fallen, the resident was assessed and a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

During stage 1 of the Resident Quality Inspection (RQI), one resident triggered for having experienced a fall.

One RPN stated that when a resident experienced a fall, the resident was to be assessed and they (the RPN) would document the fall and the assessment in PCC under a falls progress note. The RPN stated that they did not complete any further assessments.

One Registered Nurse (RN) stated that when a resident had a fall, after the resident had been assessed, a Risk Management entry, a pain assessment and a post fall assessment were to be completed. The RN and inspector reviewed the clinical record for the identified resident and were not able to locate a post fall assessment. There was a note in PCC that indicated that a post fall assessment was overdue.

The DOC stated that when a resident had experienced a fall, documentation was to be completed by the registered staff in PCC as a falls note. The DOC stated that a Risk Management note would also be completed, which would trigger a pain assessment and a post falls assessment. The DOC further stated that a post fall assessment should have been completed for the identified resident at the time of the fall as well as the risk management and pain assessment.

The licensee has failed to ensure that one resident received a post fall assessment using a clinically appropriate assessment instrument that was designed for falls. [s. 49. (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 to ensure that when the resident had fallen, the resident was assessed and a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of maintenance services, the temperature of the hot water serving all bathtubs used by residents was maintained at a temperature of at least 40 degrees Celsius.

During the RQI, one resident approached the Inspector and shared that the tub water temperature often felt cold and that parts for the water tank were ordered five months ago and have not yet been shipped to the home.

Also during the RQI, two RPN's and one PSW shared with the Inspector that the tub water temperatures were unpredictable and that many residents had voiced concerns about the water being cold. One RPN said that some residents had refused their baths because of the tub water temperature.

During an interview, one Maintenance personnel explained the following:
- the home’s hot water tanks serving resident tubs were new,

- an outside service provider rebuilt the hot water tank mixing valve,
- parts for the mixing valve were ordered approximately five months ago and have not yet been received at the home,
- an overload sensor and spring for the mixing valve were ordered two weeks ago and have not yet been received by the home,
- mixing valves on the tubs were preset to 37 Celsius (C) at the factory where the tubs were shipped from,
- the hot water tanks were serviced by an external service provider 2-3 times a week when the water temperature fell below the required temperature.

Five of seven residents interviewed told the Inspector that when they had their baths, the tub water temperature was often cool.

The Inspector observed one PSW filling the tub in the long hall with water.

When the water was turned on the digital water temperature reading on the tub was 37 C. One minute later, the digital water temperature gauge flashed and the water temperature reading changed to 34 C. Another minute later, the digital water temperature gauge flashed again and the water temperature reading changed to 34.5 C.

The identified PSW agreed after immersing their hand in the the tub water, that the water was cool and not as warm as it should be. The PSW said that during baths, some, not all of the residents commented that the tub water was cool.

The DOC acknowledged there have been concerns with the tub water temperatures, that an external service provider has attended the home on many occasions to address the water temperature concerns and that they were aware parts had been ordered to resolve the issue. The DOC also said they were not aware of resident bath refusals due to water temperature concerns.

The licensee has failed to ensure that the temperature of the hot water serving all bathtubs used by residents was maintained at a temperature of at least 40 degrees Celsius. [s. 90. (2) (i)]

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 too ensure as part of the organized program of maintenance services, the temperature of the hot water serving all bathtubs used by residents is maintained at a temperature of at least 40 degrees Celsius, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A. During the RQI, medication incident reports were reviewed for the last full quarter of 2017.

A medication incident report for one resident revealed that on one identified date, the resident was administered twice the amount of one medication ordered by the physician.

The clinical record for the resident stated the dose, frequency and time the resident was to receive the medication. The medication administration record (MAR) for the identified resident stated that the medication was administered to the resident as ordered by the physician.

One RPN acknowledged that they administered two doses of the medication in error.

The Administrator and DOC told the Inspector that the resident was administered two doses of the medication instead of one dose on the date and time identified on the medication incident report..

B. The clinical record for a second resident reflected the physician's orders for two prescribed medications.

The MAR for the identified resident stated that on one identified date, at a specific time, the resident was administered one tablet of each medication. The progress note for the resident included documentation by one RPN that they administered both medications twice to resident.

One RPN acknowledged that they administered the medications twice to the resident after they were distracted.The RPN advised that they noted the error when preparing another medications for same resident. The RPN shared that the documentation in the residents’ progress notes on the same date about the medication error, was completed by them.

The Administrator and DOC told the Inspector that the identified RPN administered two doses of the same medications to the resident on the same date and time as the medication incident report.

Administrator #100 and DOC #115 shared with the inspector that they expected registered staff to administer medications to residents as ordered by the physician. [s. 131. (2)]

2. The licensee has failed to ensure that no resident administered a drug to himself or herself unless the administration had been approved by the prescriber in consultation with the resident.

During an interview, the DOC told the Inspector that one resident self-administered their own medication at a specific time of the day.

The identified resident advised the Inspector about self-administration of their medications.

One RN shared with the Inspector that they were aware of the practice with the resident's medications and outlined the method used for the resident to self-administer their medications. The RN further shared that the resident did not have a physician’s order to self-administer the medications discussed.

One RN and the Inspector reviewed the clinical record for the resident. The clinical record did not include a physician’s order for the identified resident to self-administer the medications discussed.

The DOC acknowledged that residents could not self-administer a drug to himself or herself unless there was a physician’s order permitting them to self-administer medication.

The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (5)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 4th day of April, 2018

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

Original report signed by the inspector.