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
Jun 30, 2021	2021_797740_0016	006718-21, 006719-21, 008001-21, 008872-21	Critical Incident System

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

SAMANTHA PERRY (740), CHRISTINA LEGOUFFE (730)

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 23, 24 and 28, 2021.

The following intakes were completed within the Critical Incident Systems and Follow Up inspections:
Log# 008001-21 / CI# 2652-000005-21 related to falls management;
Log# 008872-21 / CI# 2652-000007-21 related to allegations of staff to resident abuse;
Log# 006718-21 for Compliance Order (CO) #001 from inspection #2021_797740_0007 related to the safety and security of the home;
Log# 006719-21 for Compliance Order (CO) #002 from inspection #2021_797740_0007 related to compliance with the home's abuse policy.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Housekeepers and Residents.

The inspector(s) also made various observations, including Infection Prevention and Control practices, room temperatures and reviewed residents' clinical records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #002	2021_797740_0007	740
LTCHA, 2007 S.O. 2007, c.8 s. 5.	CO #001	2021_797740_0007	740

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. 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004's right to be treated with dignity, courtesy and respect, was promoted.

The Ministry of Long-Term Care (MLTC) received a Critical Incident Systems (CIS) report regarding an incident in which staff had reported that resident #004 was upset related to an interaction with a specific staff member, and it was documented that the resident was visibly upset throughout their morning routines on the day of the incident.

The specific staff member said they had provided care to resident #004 that morning and the resident had become agitated and was yelling at them, so they left the room. A staff member said they found resident #004 visibly upset and when asked the resident said they were upset with the specific staff member. The staff member also said the specific staff member continued to engage with resident #004 despite the resident's level of agitation. Another staff member said it was reported to them that the specific staff member was pushy and rude when engaging with resident #004 and the resident was visibly upset.

Director of Nursing #101 said the specific staff member did not respect resident #004's right to be treated with dignity, respect, and courtesy. There was an increased risk to the resident's well-being when the resident's right to be treated with dignity, courtesy and respect was not promoted.

Sources: Resident #004's clinical records and interviews with Director of Nursing #101 and other staff. [s. 3. (1) 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 by complying with all residents' rights, including but not limited to, all residents being treated with respect and dignity, to be implemented voluntarily.

WN #2: 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 has failed to ensure that the plan of care for resident #001 provided clear direction related to transferring.

Resident #001’s most recent transfer assessment documented a certain level of assistance required. One of the resident's clinical records indicated the resident required an extensive level of assistance for transferring but did not indicate the specific type of assistance required. While, another clinical record documented a different more specific type of transfer assistance.

Staff member #105 said they used the clinical records posted in the residents' rooms to determine a resident's required level of assistance. They said that resident #001’s room record indicated a specific level of assistance and they were unaware of any documented changes. Physiotherapist (PT) #103 said that they had completed a transfer assessment for resident #001 and had documented the update. Registered Nurse (RN) #102 said the resident’s clinical record did not state what level of assistance the resident required and should have, and the resident's room record had not been updated to reflect the change, but should have been.

There was minimal risk of harm to Resident #001 as a result of the inconsistencies in their clinical records, which did not provide clear direction related to the resident's transfer status.

Sources: Clinical records for Resident #001, observations of Resident #001’s room, and interviews with registered and non-registered staff. [s. 6. (1) (c)]

Issued on this 2nd day of July, 2021

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

Original report signed by the inspector.