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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 22, 2018	2018_655679_0029	023621-17, 029219-17, 029535-17, 000725-18, 002616-18, 002644-18, 002886-18, 004166-18, 008790-18, 008905-18, 012257-18, 017604-18, 021062-18, 025215-18, 027104-18	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

MICHELLE BERARDI (679), TIFFANY BOUCHER (543)

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): November 5-9, 2018, and November 13-16, 2018.

The following intakes were inspected upon during this inspection:

- Four logs regarding outbreak management;

- Three logs regarding resident to resident altercations;

- One log regarding alleged staff to resident sexual abuse; and,

- Seven logs regarding resident falls.

Complaint Inspection #2018_655679_0028, and Follow Up Inspection #2018_655679_0027, were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Assistant Director of Care (ADOC), Nurse Practitioner (NP), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the Behavioural Supports Ontario (BSO) PSW, residents and their families.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, staff education records, complaint records, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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. (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).

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).

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 there was a written plan of care for each resident that set out the planned care for the resident.

A CI report was submitted to the Director for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CI report identified that resident #004 fell and sustained an injury.

Inspector #679 observed a progress note which identified the use of a specified fall prevention device.

Inspector #679 reviewed the resident's electronic care plans and did not identify the use

of the specified fall prevention device.

In an interview with PSW #118 they identified that resident #004 used a specified device as an intervention to prevent falls. In a separate interview with PSW #106 they identified that interventions to prevent falls would be listed in a residents care plan.

In an interview with RN #108 they identified that interventions to prevent falls would be listed in a resident's care plan.

A review of the policy document titled "Documentation- Plan of Care and Care Plan Definitions" identified that the plan of care must include the planned care for the resident.

In an interview with the DOC they confirmed that they did not observe the use of the specified device in the care plan, and identified that it should have been listed within the care plan. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

Two Critical Incident (CI) reports were submitted to the Director for incidents of resident to resident abuse, in which resident #003 was physically responsive towards residents #002 and #004.

A) Inspector #679 reviewed resident #003's paper chart and identified three Dementia Observation System (DOS) charting records for a specified period of time. The Inspector noted documentation to be missing on a specified number of occasions.

B) Inspector #679 reviewed resident #002's paper chart and identified a DOS charting record for a specified period of time. The Inspector noted documentation to be missing on a specified number of occasions.

C) Inspector #679 reviewed resident #011's paper chart and identified a DOS charting record for a specified period of time. The Inspector noted documentation to be missing on a specified number of occasions.

A review of the policy entitled "Documentation- Plan of Care VII-C-10.70-SSLI" last revised April 2018, identified that staff were to document the care provided, as specified

in the plan of care.

In an interview with PSW #104 they identified that DOS charting was completed for any resident exhibiting behaviours that were out of their norm. PSW #104 indicated that this helped keep track of the residents triggers and identify if their behaviours were increasing or decreasing. PSW #104 identified that the DOS charting was captured on the "Dementia Observation System" document. Together, Inspector #679 and PSW #104 reviewed the DOS charting record. PSW #104 confirmed it was the home's expectation that the documentation was completed at each time interval.

In an interview with RPN #105 they identified that DOS charting would be completed if there was a medication change or a change in a resident's behaviours. RPN #105 identified that registered staff would initiate the DOS charting, and that it was the responsibility of the PSWs to complete the documentation. RPN #105 confirmed that the documentation was to be completed on the DOS charting document. Together, Inspector #679 and RPN #105 reviewed the DOS charting record. RPN #105 confirmed it was the home's expectation that the documentation was completed.

In an interview with the DOC they identified that the home implemented DOS charting when there were medication changes, when requested by the physician/nurse practitioner, or for behaviours. Together, Inspector #679 and the DOC reviewed the DOS charting records, and the DOC identified that the documentation should have been complete. [s. 6. (9) 1.]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the care set out in the plan of care had not been effective.

A CI report was submitted to the Director for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CI report identified that resident #002 fell and sustained an injury.

Inspector #679 reviewed the post fall assessments in Point Click Care (PCC) and identified that resident #002 had a specified number of falls since their admission.

Inspector #679 reviewed resident #002's previous and most recent care plans, which all identified the same specified fall prevention interventions.

Inspector #679 reviewed the electronic progress notes and identified that the interventions to prevent falls were re-assessed after a specified number of the residents falls.

A review of the policy entitled "Documentation- Plan of Care VII-C-10.70-SSLI" last revised April 2018, identified that staff were to reassess and update the care set out in the plan of care as required if the care was no longer necessary or it had not been effective; consider different approaches in the revision of the plan of care.

In an interview with RPN #115 they identified that fall prevention interventions were to be assessed at least monthly, and after each fall.

In an interview with ADOC #117, who was also the fall prevention program lead, they identified that fall prevention interventions would be reassessed if a resident was having multiple falls.

In an interview with the DOC, they identified that fall prevention interventions were assessed at minimum quarterly, and when staff were completing the post fall huddle, to determine what interventions were working and which interventions were not working. Inspector #679 reviewed the electronic care plans with the DOC, and the Inspector identified that they did not observe that the interventions for fall prevention were reassessed for resident #002. [s. 6. (10) (c)]

4. A CI report was submitted to the Director for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CI report identified that resident #004 fell and sustained an injury.

Inspector #679 reviewed the post fall assessments in PCC and identified that resident #004 had a specified number of falls since their admission.

Inspector #679 reviewed resident #004's previous and most recent care plans, which all identified the same specified fall prevention interventions.

Inspector #679 reviewed the electronic progress notes and did not identify progress notes to indicate that resident #004's fall prevention interventions were re-assessed after their falls.

In an interview with RPN #115 they identified that fall prevention interventions were to be assessed at least monthly, and after each fall.

In an interview with ADOC #117, who was also the fall prevention program lead, they identified that fall prevention interventions would be reassessed if a resident was having multiple falls.

In an interview with the DOC they identified that fall prevention interventions were assessed at minimum quarterly, and when staff were completing the post fall huddle, to determine what interventions were working and which interventions were not working. Inspector #679 reviewed the electronic care plans with the DOC, and the Inspector identified that they did not observe that the interventions for fall prevention were reassessed for resident #004. [s. 6. (10) (c)]

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 ensuring that the provision of care set out in the plan of care is documented, specifically ensuring that the Dementia Observation System (DOS) documentation is completed; and, ensuring that when a resident has fallen, that the plan of care is reviewed and revised at least every six months, and at any other time when the care set out in the plan of care has not been effective, to be implemented voluntarily.

Issued on this 22nd day of November, 2018

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

Original report signed by the inspector.