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
Aug 25, 2020	2020_679687_0009	006704-20	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

LOVIRIZA CALUZA (687), KEARA CRONIN (759)

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): August 17 to 21, 2020.

The following intake was inspected during this Critical Incident System (CIS) Inspection.

- One intake related to a resident fall that resulted in an injury.

A Complaint (CO) Inspection #2020_679687_00010 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Food Service Manager (FSM), Director of Environmental Services (DES), Physician, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Minimum Data Set-Resident Assessment Instrument (MDS-RAI) Coordinator, Receptionist, Personal Support Workers (PSWs), Dietary Aides (DAs), family members and residents.

The Inspector(s) also conducted a daily walk through of resident care areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed residents' health records, staffing schedules, internal investigations and the home's 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1.The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #001 so that their assessments were integrated, consistent with and complemented each other.

The home submitted a Critical Incident (CI) report to the Director, which indicated that resident #001 had a fall incident which resulted in an injury.

Inspector #759 reviewed resident #001's electronic progress notes documented by Registered Nurse (RN) #112, it indicated that resident #001 displayed a specified action when a Personal Support Worker (PSW) was redirecting them out of a co-resident's room.

In a subsequent record review, Inspector #759 had further identified that resident #001’s electronic progress notes titled “Interdisciplinary Care Conference” on a specified date indicated that resident #001 was at a specified risk for falls and continues to ambulate with a specified mode for locomotion.

A review of resident #001's Minimum Data Set (MDS) assessment by Inspector #759, the Inspector identified that resident #001 had specified modes for locomotion.

Inspector #759 reviewed resident #001's electronic care plan on a specified date which indicated that the resident had a falls prevention intervention. The Inspector further identified that the falls prevention intervention that was outlined relating to resident #001’s mode for locomotion was resolved on a specified date.

A review of the home’s policy titled "Falls Prevention & Management" policy number VII-

G-30.10, last revised February 2020, it indicated that "Each member of the Interprofessional Team would document all interventions added and implemented in the plan of care, and would be evaluated on a quarterly basis".

During separate interviews conducted by Inspector #759 with PSW #101 and RN #103, they both indicated that resident #001 would use a specified mode of locomotion for ambulation.

Inspector #759 interviewed the Director of Care (DOC) and reviewed resident #001's care plan that was completed on a specified date. Inspector #759 reviewed the resident's falls prevention intervention in relation to the specified mode of locomotion for ambulation which was resolved on a specified date. Together, the DOC and Inspector#759 reviewed resident #001's electronic progress notes and were unable to identify any documentation to support the removal of the falls prevention intervention for locomotion from the resident's care plan. The DOC indicated that they expected "a note or something" to support why the resident's falls prevention intervention for locomotion was resolved from their care plan. [s. 6. (4) (a)]

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 staff and others involved in the different aspects of care of the resident collaborated with each other, in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

Issued on this 27th day of August, 2020

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

Original report signed by the inspector.