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
May 3, 2019	2019_790730_0010	001450-19, 006602-19	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

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): April 29 and 30, 2019.

The following Critical Incident intakes were completed within this inspection:

Related to falls prevention
Critical Incident Log #001450-19/ CI 2652-000001-19
Critical Incident Log #006602-19/ CI 2652-000002-19

During the course of the inspection, the inspector(s) spoke with an Administrator, Personal Support Workers (PSWs), a Registered Practical Nurse (RPN), Registered Nurses (RNs), and a Physician.

The inspector(s) also observed resident rooms and common areas, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, and reviewed policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **3 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	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. (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 when a resident was reassessed, the plan of care was reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long- Term Care (MOHLTC). The CIS report stated that resident #001 fell and sustained an injury.

A Safe Ambulatory Lift and Transfer (S.A.L.T) assessment was completed in Point Click Care (PCC), on a specified date, for resident #001. The assessment showed that resident #001 had a specified transfer status. It also indicated that the care plan had been updated to reflect the specified transfer status and that a corresponding transfer logo was in place for staff to access.

During an observation of resident #001 in their room, inspector #730 observed a logo above the resident's bed that indicated that they had the same specified transfer status as indicated by the S.A.LT. assessment.

A review of resident #001's plan of care showed that it had not been updated to reflect that the resident had the transfer status specified by the S. A. L. T assessment until a date approximately two weeks after the assessment was conducted.

A review of the assessments tab in PCC showed a Fall Risk Assessment with a specified date. This assessment indicated that the resident was at a specified risk for falls. During a quarterly falls risk assessment, on a prior date, resident #001 had been assessed as different risk level for falls.

A review of the current plan of care for resident #001 showed two contradicting focuses related to risk for falls.

During an interview with RN #102, they stated that registered staff and management were responsible for updating plans of care for residents. RN #102 stated that resident #001 had a specified transfer status, after their fall, but the plan of care had not been updated and the differing falls risk focus should have been removed from the plan of care, as resident #001 was at a different risk for falls than indicated.

2. The home submitted a CIS report to the MOHLTC. The CIS report stated that resident #002 fell and sustained an injury.

During an observation of resident #002's room, inspector #730 observed a transfer logo above the resident's bed, which indicated that the resident had a specified transfer status.

During an interview with PSW #108, they stated that they were familiar with resident #002, that the transfer logo was accurate and that the resident typically required the level of assistance specified on the transfer logo, or a higher level if they were tired.

During an interview with RN #105, they stated that after the resident's fall they used the same amount of assistance to transfer as before the fall. This level differed from what was indicated on the transfer logo.

During an interview with RN #102, they stated that resident #002 currently had a specified transfer status, which was the same as indicated by RN #105.

Review of a S.A. L. T. assessment for resident #002 stated that the resident had the same transfer status as indicated by the transfer logo.

A review of a Rehabilitation/Physical Therapy Referral in PCC for resident #002, related to their fall, stated that the resident continued to have a specified transfer status. This was the same transfer status as stated by RNs #105 and #102.

A review of the current plan of care for resident #002 showed a different transfer status than noted during the documented interviews, assessments, or observations. There were no cancelled or resolved interventions/tasks with a transferring focus.

During an interview, RN #102 stated that resident #002's plan of care and transfer logo should be updated to show the resident's current transfer status.

The licensee has failed to ensure that the plan of care was revised when resident #001 and #002's care needs changed related to falls prevention.

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 the written plan of care for each resident is reviewed and revised when a resident's care needs change, 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 a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate instrument that was specifically designed for falls.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long- Term Care (MOHLTC). The CIS report stated that resident #001 and sustained an injury. A post-fall assessment was completed for the reported fall.

A progress note, with a later date than the CIS report, for resident #001, indicated that the resident had sustained another fall. No injury was noted.

The home's policy titled "Fall Prevention Program Components of Fall Prevention Program" with an effective date of January, 2016, stated components of the Fall Prevention Program included nine points with point six being: "6. Documentation of falls as an incident in Point Click Care. Risk management and documentation of falls in resident progress notes."

During an interview, RN #102 said there was no post-fall assessment completed in the Risk Management section of Point Click Care (PCC) for the second fall. Both RN #102 and RN #104 stated that it would be their expectation that a post-fall assessment would have been completed within the "Risk Management" section by registered staff, as per the home's policy.

Based on these interviews and record reviews the licensee has failed to ensure that when resident #001 had fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

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 a resident falls, 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 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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident under subsection (1) (3) or (3.1), within 10 days of becoming aware of the incident, with the names of any residents involved in the incident and the outcome or current status of the individual or individuals who were involved in the incident.

The home submitted Critical Incident System (CIS) report to the Ministry of Health and Long- Term Care (MOHLTC) related to a fall. The CIS report identified the resident by their first name and no surname was included.

The home submitted another CIS report to the MOHLTC, related to a fall. Within the documentation for the CIS report the question "What is the outcome/current status of the individual(s) who was/were involved in this occurrence?" stated that the resident was awaiting assessment from the physician. A progress note in Point Click Care, for resident #002, titled Registered Staff Note, stated that the resident had been found to have a specified injury. The CIS report was not updated by the home to include further information regarding the status of the resident after the incident.

During interviews with Administrator #100, they stated that it would be their expectation that CIS reports would include the resident's surname and be updated to include further information regarding the status of the resident after an incident.

The licensee failed to ensure that the Director was informed of an incident under subsection (1) (3) or (3.1), within 10 days of becoming aware of the incident, with resident #001's name and the outcome or current status of resident #002.

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Issued on this 6th day of May, 2019

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

Original report signed by the inspector.