Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Original Public Report

Report Issue Date: December 1, 2022	
Inspection Number: 2022-1159-0001	
Inspection Type: Critical Incident System	
Licensee: QCC Corp.	
Long Term Care Home and City: Watford Quality Care Centre, Watford	
Lead Inspector Debbie Warpula (577)	**Inspector Digital Signature** Debbie L Warpula Digitally signed by Debbie L Warpula Date: 2022.12.02 16:10:19 -05'00'
Additional Inspector(s) Karen Honey (740899)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 21, 22, 23 and 24, 2022.

The following intake(s) were inspected:

- Intake #00001844 related to a resident fall with injury;
- Intake #00002233 related to a resident fall with injury;
- Intake #00003068 related to a resident fall with injury;
- Intake #00007193 related to a resident fall with injury; and
- Intake #00010949 related to a resident fall with injury.

The following **Inspection Protocols** were used during this inspection:

Falls Prevention and Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls Program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee has failed to ensure that when two residents fell, a specific monitoring record and subsequent particular note for a resident were completed in full.

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure the home's falls prevention and management program was in place, and ensure it was complied with.

Specifically, staff did not comply with the licensee's Head Injury Routine policy and Post Fall Management policy which was part of the licensee's Falls Prevention and Management Program.

Rationale and Summary:

Two different Critical Incident (CIS) System reports were submitted to the Director on an identified dates, concerning two residents who had unwitnessed falls and required medical care.

Review of the home's policy "Fall Prevention Program-Post Fall Management Policy – 5.1" effective January 2022, indicated that registered staff were to document a progress note as a "Fall with Injury" or "Fall without Injury" post fall and implement a Head Injury Routine (HIR) for all unwitnessed falls.

A review of the home's policy "Head Injury Routine" effective January 2022, indicated that staff were to monitor vital signs and pupils for 72 hours (hrs) post fall; staff were to assess and document on the monitoring record every 15 minutes for the first hour, every 30 minutes for one hour, every hour for six hours, every two hours for following eight hours, every four hours for eight hours and every eight hours for the following 48 hours.

During a record review of a resident's records, Inspector #577 noted a missing particular note.

Their specific monitoring record was missing a particular number of assessments.

During a record review of a resident's records, Inspector #577 noted that their specific monitoring record was missing a particular number of assessments.

During an interview with the Administrator, together with Inspector #577, reviewed two resident's specific monitoring records. They confirmed that staff did not complete the records as required, and one resident was missing a particular note.

The home not completing two resident's specific monitoring records put the residents at risk as they failed to assess their particular status as required.

Sources: review of two CIS reports, review of two resident's progress notes and specific monitoring records, review of the home's "Fall Prevention Program-Post Fall Management Policy – 5.1" effective January 2022, and "Head Injury Routine" effective January 2022, an interview with the DOC and Administrator.

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