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
Jan 30, 2020	2020_829757_0003	020951-19	Critical Incident System

Licensee/Titulaire de permis

Atikokan General Hospital
120 Dorothy Street ATIKOKAN ON P0T 1C0

Long-Term Care Home/Foyer de soins de longue durée

Atikokan General Hospital
120 Dorothy Street ATIKOKAN ON P0T 1C0

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

DAVID SCHAEFER (757)

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): January 20-24, 2020.

The following intake was inspected during this inspection:
- One intake, related to a resident fall that resulted in a transfer to hospital.

A Sudbury Service Area Office initiated inspection (#2020_829757_0004) was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Acting DOC, Resident Assessment Instrument (RAI) Coordinator, Infection Control/Risk Manager, a Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, staff-to-resident interactions, and reviewed relevant resident health care records, internal incident reports, as well as specific licensee policies, procedures, and programs.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to residents as specified in the plan.

a) The home submitted a Critical System Incident (CIS) report which indicated that resident #001 had a fall while self-ambulating. The report identified that RPN #105 initially responded to the fall. The fall resulted in the resident being transferred to hospital, where it was determined they had incurred an injury.

The inspector conducted a review of resident #001’s care plan from the time of the fall, which indicated that staff were to implement specific falls interventions.

During an interview with Registered Practical Nurse (RPN) #105, they stated that resident #001 was found to be without a specific intervention implemented when they responded to the fall, as specified in the resident's plan of care.

b) The inspector conducted a record review of resident #005’s current care plan, which indicated that the resident was a high risk for falls, and had fallen recently. The care plan identified that the resident was to have specific falls interventions.

During an observation of resident #005’s room, the inspector noted that there was a specified falls prevention intervention not implemented. The inspector conducted an interview with the Resident Assessment Instrument (RAI) Coordinator, who confirmed that the intervention was not implemented.

The inspector conducted another observation of resident #005's room, where the resident was observed sleeping in bed; however, two other falls interventions had not been implemented. The inspector conducted an interview with Personal Support Worker (PSW) #108, who confirmed that the interventions had not been implemented as specified in the plan of care.

During an interview with the acting Director of Care (DOC), they confirmed that care had not been provided to resident #001 and resident #005, as specified in their plans of care. [s. 6. (7)]

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 the care set out in the plan of care is provided to residents as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act and Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any strategy, the strategy was complied with.

In accordance with Ontario Regulation (O. Reg.) 79/10, s. 48 (1) 1., and in reference to O. Reg. 79/10 s. 49 (1), the licensee was required to ensure that a falls prevention and management program to reduce the incidence of falls and the risk of injury was implemented in the home, and which provided strategies to monitor residents.

Specifically, staff did not comply with the home's policy "Fall Prevention and Management Program for LTC, ECW LONG TERM C-POL-POLICIES AND PR-6582", dated effective September 16, 2019. The policy required that registered staff, when a resident has fallen, and where the fall was unwitnessed, to initiate a Head Injury Routine (HIR) using the paper document "Appendix E: Post-Falls Neurological Observation Record".

This inspector reviewed the home's "Falls Tracking Tool", and identified the following residents with recent unwitnessed falls:
- Resident #001 – one unwitnessed fall.
- Resident #004 – three unwitnessed falls.
- Resident #005 – one unwitnessed fall.

The inspector conducted a review of resident #001, #004, and #005's health records, and found no record that the Post-Falls Neurological Observation Record had been completed for any of these residents' five unwitnessed falls. The RAI Coordinator reviewed resident #001, #004, and #005's health records together with the inspector and confirmed that the Post-Falls Neurological Observation Record had not been completed for any of these five unwitnessed falls.

During an interview with the acting DOC, they reviewed resident #001, #004, and #005's charts with the inspector, confirmed that the Post-Falls Neurological Observation Records had not been completed for the five unwitnessed falls, and stated that staff did not follow the home's Falls Prevention and Management Program. [s. 8. (1) (b)]

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 where the Act and Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any strategy, the strategy is complied with, to be implemented voluntarily.

WN #3: 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 residents had fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

a) The home submitted a CIS report which indicated that resident #001 had a recent fall. The resident was discovered on the floor in pain and distress, and was subsequently transferred to hospital, where it was determined they had incurred an injury.

b) The inspector reviewed resident #005’s electronic progress notes which identified the resident had a recent fall. The progress note indicated that the resident's initial post-fall assessment identified the resident had pain and a visible injury. A review of the homes “Falls Tracking Tool” identified that the resident was subsequently transferred to hospital, where it was determined they had incurred an injury.

A review of resident #001 and resident #005’s records found that no clinically appropriate assessment instrument specifically designed for falls had been completed for either

resident following their falls.

The home's policy "Fall Prevention and Management Program for LTC, ECW LONG TERM C-POL-POLICIES AND PR-6582", effective September 16, 2019, stated that "when a resident has fallen, the resident will be assessed, and a post fall assessment completed". After a resident has fallen, the policy required registered staff to complete the following documentation post-fall: a Fall Risk Assessment Tool (FRAT), an electronic falls incident report, and an electronic progress note. The policy made no mention of a clinically appropriate post-fall assessment instrument that was specifically designed for falls.

During a review of the home's falls binder, the inspector noted a falls program appendix titled "Appendix F: Post Fall Assessment/Incident Form", which included a post-fall assessment instrument that was specifically designed for falls.

During an interview with RPN #105, they stated that the document "Appendix F: Post Fall Assessment/Incident Form" had been discontinued from use in the home approximately six months prior, and had been replaced with an electronic incident reporting system.

A review of the electronic incident reports completed for resident #001 and #005's falls, found that the electronic reporting system was missing the following assessments included in the formerly used "Appendix F: Post Fall Assessment/Incident Form":
- Immediate vital signs at time of the fall
- Resident's response when asked "Why do you think you fell?"
- Indication to complete neurological observation for an unwitnessed fall or fall resulting in head injury
- Mental status of resident after the fall
- Physical status of resident at time of the fall
- Footwear at the time of the fall
- Medication review
- Staff safety huddle
- Falls prevention committee review

During an interview with the acting DOC, they confirmed that the home's electronic incident reports, FRAT, and electronic progress notes did not constitute a clinically appropriate post-fall assessment instrument that was specifically designed for falls. [s. 49. (2)]

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 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, to be implemented voluntarily.

Issued on this 30th day of January, 2020

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

Original report signed by the inspector.