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 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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 13, 2017	2017_644507_0001	020733-16	Critical Incident System

Licensee/Titulaire de permis

BETHANY LODGE FOUNDATION
23 Second Street MARKHAM ON L3R 2C2

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

BETHANY LODGE
23 Second Street MARKHAM ON L3R 2C2

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

STELLA NG (507)

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): February 3, 6 and 8, 2017.

During the course of the inspection, the inspector(s) spoke with the Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Registered Practical Nurse (RPN) and Personal Support Worker (PSW).

The inspector conducted observation of staff and resident interactions, provision of care, record review of resident and home records, staffing schedules, staff training record and relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **2 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	Legendé 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 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 :

The licensee has failed 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.

An identified Critical Incident Report (CIR) was submitted to the Ministry of Health and Long Term Care (MOHLTC) related to a fall incident that revealed resident #001 sustained an injury from the fall.

Review of the home's policy titled "Falls prevention and Management" (policy #:RCS-1-NURS-RESIDENT CARE-380, revised December 2015) indicated that when a resident has fallen, the interdisciplinary team were required to complete an electronic Post Fall Investigation (PFI) and input the summary portion into the Post Falls Investigation Incident note in the electronic record.

Review of resident #001's progress notes for an identified five month period revealed the resident had six falls. Review of the electronic health record failed to reveal a completed Post Fall Investigation (PFI) in relation to resident #001's fall occurred on an identified date.

Interviews with RAI-Coordinator #102 and ADOC #103 revealed that registered staff are required to conduct the post fall assessment by completing the PFI on the computer after a resident has fallen. Staff #102 and #103 confirmed that a PFI was not completed in relation to resident #001's fall occurred on the above mentioned identified date. [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.

WN #2: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the Director is informed of an incident under subsection (3) where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, and the injury has resulted in a significant change in the resident's health condition.

An identified Critical Incident Report (CIR) was submitted to the MOHLTC related to a fall incident that revealed resident #001 sustained an injury from the fall.

Review of resident's progress notes revealed resident #001 had a fall on an identified date. After the fall incident, the resident complained of pain. An x-ray report dated three days later revealed resident #001 sustained a fracture. On the following day, the resident was taken to the fracture clinic in the hospital and received treatment.

Review of the identified CIR and progress notes revealed that resident #001 had a fall on an identified date, the home was aware of the fracture three days later. On the fourth day, the resident was taken to the hospital because of the injury sustained from the fall. Review of the CIR revealed that the CIR in relation to resident #001's fall incident was submitted to the Ministry of Health and Long Term Care six business days later.

Interview with ADOC #103 confirmed that the home did not submit the CIR within one business day as required. [s. 107. (3)]

Issued on this 15th day of February, 2017

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

Original report signed by the inspector.