Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
Oct 8, 2019	2019_739694_0020	012274-19	Critical Incident System

Licensee/Titulaire de permis

MacGowan Nursing Homes Ltd.
719 Josephine Street P.O. Box 1060 WINGHAM ON N0G 2W0

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

Braemar Retirement Centre
719 Josephine Street North, R.R. #1 P.O. Box 1060 WINGHAM ON N0G 2W0

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

AMANDA COULTER (694)

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): September 26 and 27, 2019.

Log #012274-19, related to fall prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Quality Nurse, Registered Nurses (RN), Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspector toured the facility, observed the provision of resident care, reviewed resident clinical records, and reviewed the facility's policies.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Resident Charges

During the course of this inspection, Non-Compliances were issued.
- **3 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 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 :

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

In accordance with O. Reg. 79/10, s. 48(1) and in reference to s. 49(1), the licensee was required to have a falls prevention and management program that provided strategies to monitor residents.

Specifically, staff did not comply with the licensee's policies, "Falls Prevention Policy and Procedure" and "Head Injury Routine", that directed staff to initiate increased monitoring and document at specific intervals for any resident that had a fall and sustained a head injury or may have potentially sustained a head injury.

Four residents that had unwitnessed falls were reviewed. A number of the entries on the head injury routines were not completed post fall.

In interviews with staff they said it was an expectation of registered staff to complete the increased monitoring tool at the specified intervals. They were unsure why there was no documentation at the required intervals.

The licensee failed to ensure their strategy related to the implementation and completion of a head injury routine when a resident had an unwitnessed fall, was complied with. [s. 8. (1) (a),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 or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any procedure, specifically a head injury routine within the falls prevention and management program and that the procedure is complied with, to be implemented voluntarily.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

The licensee failed to ensure that there was a written plan of care for a resident that set out the planned care for the resident in relation to the use of fall prevention equipment.

A specific resident had a fall and the identified resident sustained an injury which required transfer to hospital. The identified resident's substitute decision maker (SDM) requested the resident use a specified piece of equipment for fall/ injury prevention.

Staff confirmed the specified equipment was not in the identified resident's plan of care.

The licensee failed to ensure that there was a written plan of care for a resident that set out the planned care for the resident in relation to the use of fall prevention equipment.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 245. Non-allowable resident charges
The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:
1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.
2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.
3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.
4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.
5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.
6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.
7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.
8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

The licensee failed to ensure that a resident was not charged for goods and services that the licensee was required to provide to a resident using funding that the licensee received from the local health integration network and/or the Minister.

During a CI inspection, when staff were interviewed regarding the use and availability of falls/injury prevention equipment in the home, staff explained that for certain pieces of equipment the resident's could trial the home's equipment and then purchase if they wanted their own.

Staff provided Long-Term Care Home (LTCH) inspector#694 an invoice for an identified resident that their account was charged for pieces of falls/injury prevention equipment.

The licensee failed to ensure a resident, was not charged for goods and services that the licensee was required to provide to a resident using funding that the licensee received from the local health integration network and/or the Minister. [s. 245. 1.]

Issued on this 22nd day of October, 2019

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

Original report signed by the inspector.