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 27, 2020	2020_792659_0001	022456-19, 023832-19, 000529-20	Complaint

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

JANETM EVANS (659)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 6, 7 and 8, 2020.

The following intakes were included in this inspection:
Log #022456-19\CI 2788-000010-19; Log #023832-19\IL-72988-CW and Log #000529-20\CI 2788-000001-20 related to a resident fall with injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, DIrector of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), the Resident Assessment Instrument Coordinator (RAI-C), Personal Support Workers (PSW), Physiotherapy Aid, and Office Manager.

During the course of the inspection observations were made of staff to resident interactions, transfers, logos and relevant clinical records, schedules and policies and procedures.

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 care set out in the plan of care was provided to an identified resident as specified in the plan. Specifically, the licensee failed to ensure that fall prevention interventions for the identified resident were followed as specified in the plan.

A complaint was received to the MLTC related to a fall with injury for an identified resident.

A post fall assessment documented the identified resident sustained a fall on a specified date. They were assessed and transferred to hospital.

The clinical records showed the resident was at risk for falls. They had two prior falls in the last six months. They required extensive to total assistance with all Activities of Daily Living (ADL's).

A physiotherapy assessment documented that the identified resident required a full lift for safe transfers.

The resident's care plan for falls, documented that the call bell should be accessible when they were in bed; a safety device was to be used while the resident was in bed/chair, logos were to be in place; and the resident's bed should be maintained at a specific height.

The home’s investigation documented written statements from their staff which included that at the time of the resident’s fall, their bed was in the incorrect position and their safety device did not work. Documentation included an interview with an agency PSW who acknowledged they had provided care to the resident prior to their fall. They said they did not leave the bed at the appropriate height before leaving the room.

The DOC said the identified resident’s plan of care had not been followed related to fall prevention precautions.

The licensee had failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan. Specifically, the licensee failed to ensure that fall risk interventions for resident #001 were followed as specified in the plan. [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 all staff have reviewed the plan of care for each resident they provide care to and that they follow the plan of care for falls as directed by the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no person performs their responsibilities before receiving training in the areas mentioned below.
    1. The Residents' Bill of Rights.

2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76 (2).

A complaint was received to the MLTC related to a resident fall with injury.

On the specified date of the fall incident, an agency PSW attended the identified resident prior to their fall.

Review of orientation training records for agency staff showed there was a binder which had been located at the nursing station. The binder contained the Braemar PSW orientation checklist that was to be completed by the agency staff. The checklist included a tour of the facility and assigned unit, review of the resident's care plan and Kardex, accompanying the trainer on initial rounds and charting on Point of care (POC). The document was to be signed off by the agency staff and trainer and returned to the home. There was no documented orientation training record for the agency PSW.

The home's policy and procedure binder that was to be reviewed as part of the orientation did not include policies related to the home's policy to minimize the restraining of residents, fire prevention and safety, emergency and evacuation procedures or policies of the licensee that were relevant to their responsibility such as falls prevention, safe use of lifts, or safe and correct use of equipment, including positioning aids.

Review of the home's shift schedule showed that the agency PSW was scheduled to be oriented one hour prior to the beginning of their shift on a specified date.

The agency PSW said they attended the home an hour prior to their shift. The PSW said they had a quick tour of the home, introduction to their partner and they were shown

where the charting was. When asked if they had reviewed the home's policies and procedures before starting work they said they had not.

The DOC acknowledged that the policy binder for agency did not contain all mandatory training or policies that were relevant to the persons responsibilities. When asked how they knew that Agency staff had reviewed the policies/training required prior to their working in the home the DOC said they could not say that they knew the agency staff reviewed the policies. They said there was an orientation sheet they were to review with staff from the home and sign off and return. The DOC acknowledged there was no documented orientation training record for identified agency PSW who was involved in the fall incident.

The licensee had failed to ensure that no person performs their responsibilities before receiving training in the areas mentioned below.
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76 (2) [s. 76. (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 mandatory training is completed with all staff prior to their working, this includes training on policies related to their responsibilities, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff were provided with training in falls prevention and management.

A complaint was received to the Ministry of Long Term Care (MLTC) related to a resident fall with injury.

Review of 2019 Surge training records related to falls prevention for the home's staff showed there were four parts to the falls training as follows:
Part one Falls prevention, an introduction; 29.6% or 16/54 had not completed the training.
Part two: Fall risk factors in seniors; 34.2% or 27/79 had not completed the training.
Part three: Assessment and Interdisciplinary roles; 39.2% or 31/79 had not completed the training.
Part four: Interventions in minimizing risk for falls and fall-related injuries; 35.4% or 28/79 had not completed the training.

One RPN said they did not have formalized training on falls.

The DOC said falls training was completed on Surge. They said there was a gap in ensuring the mandatory training was completed for staff and acknowledged the training for falls had not been completed for all staff in 2019.

The licensee failed to ensure that direct care staff were provided with training in falls prevention and management. [s. 221. (1) 1.]

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 all direct care staff complete annual training in falls prevention and management, to be implemented voluntarily.

Issued on this 5th day of February, 2020

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

Original report signed by the inspector.