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 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
Feb 26, 2019	2019_643111_0004	001702-19	Critical Incident System

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Case Manor Care Community
28 Boyd Street P.O. Box 670 BOBCAYGEON ON K0M 1A0

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

LYNDA BROWN (111)

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 14, 2019 and on February 15 and 19, 2019, an off-site inspection was conducted.

A critical incident inspection (CIR) was inspected related to a fall with injury.

During the course of the inspection, the inspector(s) spoke with the Associate Director of Care (ADOC), Registered Nurse (RN), Personal Support Workers (PSW) and Coroner.

During the course of the inspection, the inspector: reviewed the health record of the resident and reviewed the Falls Prevention policy.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Under O.Reg. 79/10, s. 49(1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies , devices and assistive aids.

Review of the licensee's Fall Prevention policy (VII-G-30.00) revised January 2015 indicated when a fall occurs, the Registered Staff will:
1) Assess the environment, before mobilizing, for clues as to objects which may have struck the resident during the fall or caused the fall.
2) Not move the resident if there is suspicion or evidence of injury. The physician should be contacted and/or arrange for immediate transfer to the hospital.
4) Initiate the head injury routine if a head injury is suspected or the fall is un-witnessed and he/she is on anti-coagulant therapy.
5) Monitor HIR as per the schedule on the form post fall for neurological changes, i.e. facial droop, behavioural changes, weakness on one side, etc.

Review of the health care record for resident #001 indicated the resident had no Substitute Decision Maker (SDM). Review of the progress notes indicated the resident had sustained a fall on a specified date and time. RN #100 indicated the resident was found on the floor in their room. The PSW was holding the resident's head and there was an injury to a specified area. The resident was unable to describe the fall and was lethargic. The resident was placed on head injury routine (HIR). The progress note indicated the physician was notified. The following day, a treatment was provided to the

injury at the specified area, the resident had been up for meals and denied any pain. Two days after the fall, at a specified time, the resident was found unresponsive and with a specified change in condition. The Nurse Practitioner (NP) was called and the resident was transferred to hospital for assessment. Later the same day, the hospital called the home and reported a specified diagnosis and indicated the resident would be returned to the home on end of life care. The physician was contacted and indicated the coroner would need to be contacted in the event of death. Three days later, the resident passed away.

During an interview with PSW #101 by Inspector #111, the PSW indicated on a specified date and time, they responded to resident #001's room after hearing a loud sound from another residents room. The PSW indicated they found the resident on the floor beside the bed, unconscious and with an injury to a specified area. The PSW indicated they immediately contacted staff assistance and RN #100 came to the room to assess the resident.

During an interview with PSW #103 by Inspector #111, the PSW indicated on a specified date and time, they responded to resident #001's room immediately after hearing the emergency call on their phone and they were not on the floor at the time of the fall. The PSW indicated PSW #101 was already in the room with the resident #001 and noted the resident had sustained an injury to a specified area. The PSW indicated the resident was conscious when they arrived in the room but the resident "had just come to" when they got there. The PSW indicated they thought that RN #100 assessed the resident.

During an interview with RN #100 by Inspector #111, the RN confirmed on a specified date and time, PSW #101 found resident #001 on the floor in their room. The RN indicated the resident had been in their mobility aide prior to the fall. The RN indicated when they arrived in the room, the resident was on floor with a specified injury to a specified area. The RN indicated they initiated the protocol for an un-witnessed fall. The RN denied contacting anyone regarding the fall, despite the resident having a visible injury and having sustained a loss of consciousness. The RN indicated there was no other injury noted, the resident denied any pain and a note was left for the doctor, in the doctor's book regarding the fall, which is why they indicated the physician was notified in the progress notes.

The licensee failed to ensure the falls prevention policy was complied with as, resident #001 sustained an injury to a specified area, with a loss of consciousness after sustaining a fall. The physician was not contacted and/or the resident was not

immediately transferred to hospital, as per the licensee's policy until three days later.

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 the licensee's Falls Prevention policy is complied with, 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. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

The licensee failed to ensure that the Director was 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): 4. Subject to subsection (3.1), an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

A critical incident report (CIR) was submitted to the Director on a specified date for a fall for which the resident was taken to hospital and which resulted in a significant change in condition. The CIR indicated the fall had occurred five days earlier at a specified time, when resident #001 was found on the floor and sustained an injury to a specified area. The CIR indicated that three days later, at a specified time, the resident was found with a significant change in condition. The resident was transferred to hospital for assessment which indicated a specified diagnoses and returned to the home on palliative care. The CIR was completed by the DOC.

During an interview with the DOC by Inspector #111, the DOC confirmed that on a specified date, resident #001 had sustained a fall with a specified injury, but was stable. The DOC indicated a couple of days later, the resident had a significant change in condition and was transferred to the hospital. The DOC indicated a critical incident report was submitted to the Director at that time. The DOC was made aware that the Director was not made aware for another two business days, despite the DOC being notified that the hospital contacting the home on the same day with the results of the assessment and indicating the resident would be returned to the home on palliative care. The DOC then indicated that they received a phone call from the hospital indicating the resident had a specified diagnosis, possibly from the fall and may have submitted the CIR at that time.

Review of the health record for resident #001 indicated the resident sustained a fall on a specified date and time, resulting in an injury to a specified area and had a short period of loss of consciousness. The resident then had a significant change in condition three days later and was sent to hospital for assessment. The hospital assessment confirmed the resident had a significant change in condition, was deemed palliative, returned to the home the same day and the DOC was notified.

The licensee failed to ensure the Director was informed within one business day of an incident for which resident #001 was transferred to hospital and had a significant change in condition, as the Director was not informed until two business days.

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 the Director is informed of an incident that causes an injury to the resident and results in a significant change in the resident's health condition, within one business day after the occurrence, to be implemented voluntarily.

Issued on this 4th day of March, 2019

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

Original report signed by the inspector.