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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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Feb 17, 2022 | 2022_790730_0004 | 016127-21 | Complaint |

### Licensee/Titulaire de permis

Craigwiel Gardens
221 Main Street R. R. #1 Ailsa Craig ON N0M 1A0

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

Craigholme
221 Main Street, R.R. #1 Ailsa Craig ON N0M 1A0

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

CHRISTINA LEGOUFFE (730)

## 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 31, February 1, 2, 4, 7, 8, 9, 10, 2022 (Onsite) and February 3, 2022 (Offsite).**

**The following complaint intake was completed within this inspection:**
**- Log #016127-21 related to falls prevention and management and reporting**

**Inspector #721442 (Stephanie Morrison) was also present during this inspection.**

**This inspection was conducted concurrently with Critical Incident Systems inspection #2022_790730_0003.**

**During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Assistant Director of Care (ADOC), a Physician, a Registered Dietitian (RD), Registered Nurses (RNs), a Restorative Care Personal Support Worker, Personal Support Workers (PSWs), and a resident.**

**The inspector also observed residents and the care provided to them, reviewed care records, and reviewed relevant policies and procedures of the home.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Skin and Wound Care**

**During the course of this inspection, Non-Compliances were issued.**
- **4 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 50. Skin and wound care**

**Specifically failed to comply with the following:**

**s. 50. (2) Every licensee of a long-term care home shall ensure that,**
**(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,**
**(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,**
**(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,**
**(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and**
**(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that when a resident exhibited altered skin integrity that they were assessed by a Registered Dietitian and were reassessed at least weekly by a member of the registered nursing staff.

A) A resident returned to the home from hospital with a wound. No weekly skin assessment was documented on a specified date, although there was an assessment scheduled for completion in the Treatment Administration Record (TAR).

A Registered Nurse (RN) said that the expectation was that areas of altered skin integrity, including wounds, were reassessed at least weekly. Upon review of the resident's clinical record they said that no weekly wound assessment was completed for the resident on the specified date, but should have been.

B) When a resident returned from hospital with a wound, no referral was made and no assessment was documented by the home’s Registered Dietitian.

A Registered Dietitian (RD) said that they would have expected to have received a referral related to the resident's wound when they returned from hospital, but did not. They said that they did not complete a nutritional assessment when the resident had a wound.

There was a risk that the resident's wound could have worsened in the absence of a weekly skin reassessment and assessment by the home's Registered Dietitian.

Sources: Resident clinical record including progress notes, TAR, and assessments, and interviews with an RN, RD, and other staff. [s. 50. (2) (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 when a resident exhibits altered skin integrity they are assessed by a Registered Dietitian and reassessed at least weekly by a member of the registered nursing staff, 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):**
**4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the Director was informed within one business day of an incident that caused an injury to a resident, for which the resident was taken to hospital and that resulted in a significant change in the resident's health condition.

A resident sustained an unwitnessed fall. In the days after the fall the resident was noted to have increased pain and decreased mobility. On a later date the resident had an x-ray, which indicated that the resident had a fracture. The resident was then transferred to hospital and underwent surgery.

A Physician said that they suspected that the resident had a hairline fracture as a result of a fall, which later displaced. A Restorative Care Personal Support Worker (PSW) said that after the resident's return from hospital that the resident had a significant change in their condition.

The Director of Care (DOC) said that the incident was not reported to the Director, but in hindsight should have been.

Sources: Resident clinical record including progress notes, Resident Assessment Instrument Minimum Data Set (RAI-MDS), hospital reports, and interviews with the DOC and other staff. [s. 107. (3) 4.]

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

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**WN #3: 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 the home's "Neurological Signs/Head Injury" policy was complied with for resident #004.

O. Reg. 79/10 s. 48 (1) requires a falls prevention and management program to reduce the incidence of falls and the risk of injury.

O. Reg. 79/10 s. 49 (1) requires that the program provides strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the home's "Neurological Signs/Head Injury" (revised December 2019) which stated that, "the nurse will implement a head injury routine and obtain neurological signs whenever a resident experiences or is suspected of sustaining a head injury due to a fall/incident or who have been found on the floor (experienced an unwitnessed fall)."

Head Injury Routines (HIRs) were to be completed every hour for four hours, then if stable, every four hours for 12 hours and every eight hours for 24 hours.

A resident sustained an unwitnessed fall and an HIR was initiated. On multiple occasions the assessment was not fully completed and it was documented that the resident was "sleeping."

A Registered Nurse (RN) said that HIRs were completed when a resident hit their head or had an unwitnessed fall. They said that residents should be woken up to complete the assessment and that it was not acceptable to write "sleeping" on an HIR.

The Assistant Director of Care (ADOC) said that the HIR for the resident for the specified date was not completed as per the home's policy.

The home's failure to complete the HIR for the resident placed the resident at risk for harm.

Sources: "Neurological Signs/Head Injury" policy (revised December 2019), clinical records for a resident including progress notes and head injury routine documentation; and interviews with an RN, the ADOC, and other staff. [s. 8. (1)]

**WN #4: 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 a resident fell that a post-fall assessment was conducted using a clinically appropriate assessment instrument, that was specifically designed for falls.

A resident sustained an unwitnessed fall. No post fall assessment was documented in the assessments section of Point Click Care (PCC) related to this fall.

The home's "Fall Prevention and Management Program" policy (Revised December 2019) stated that after a fall the interdisciplinary team completed a Risk Management Report and a detailed summary of the fall incident. Within the Risk Management report staff completed the required Post Fall Assessment.

A Registered Nurse (RN) said that the resident was at high risk for falls. They said that a post fall assessment should have been completed when the resident fell, but was not.

There was a risk of harm to the resident when a Post-Fall Assessment was not completed after a fall.

Sources: Resident clinical record including progress notes, assessments, and risk management, the home's policy titled "Falls Prevention and Management Program" (Revised December 2019), and interviews with an RN and other staff. [s. 49. (2)]

**Issued on this 17th day of February, 2022**

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

**Original report signed by the inspector.**