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
Aug 23, 2021	2021_575214_0009	005129-21, 007862-21	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of Niagara
1815 Sir Isaac Brock Way Thorold ON L2V 4T7

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

Deer Park Villa
150 Central Avenue Grimsby ON L3M 4Z3

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

CATHY FEDIASH (214)

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): August 11, 12, 13, 16, and 17, 2021.

The following intakes were completed during this Critical Incident System (CIS) inspection:

-log #005129-21- related to fall prevention and management.

-log #007862-21- related to fall prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care (DRC), Registered Nursing staff, Personal Support Workers (PSW), Housekeeping staff, COVID-19 staff Screener's, Maintenance Coordinator, Clinical Documentation and Informatics Lead and residents.

During the course of the inspection, the inspector reviewed CIS reports, clinical health records, temperature log sheets, manufacturers' instructions and observed the provision of care.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on an assessment of the resident's fall prevention and management needs.

A Critical Incident System report (CIS) indicated the resident had a fall that resulted in an injury. Documentation indicated the resident's fall prevention and management device had not responded.

Documentation four weeks before this incident, indicated the resident had a fall and the same fall prevention and management device had not responded. An assessment for this fall indicated staff were to check the device more frequently throughout the shift. This intervention had not been included in the resident's plan of care, including the Point of Care (POC) tasks until four weeks later, when they fell and sustained an injury.

A Registered Nurse (RN), who implemented the intervention following the residents fall with injury, indicated they had added this intervention as the device had not responded when the resident fell, the day before.

A Registered Practical Nurse (RPN) who had conducted the fall assessment when the resident fell four weeks prior, indicated the device may have not responded as the device had not stayed in place due to the type of clothing the resident had been wearing at the time. They confirmed they had not documented this assessed intervention in the resident plan of care, including in the POC tasks.

When the assessed needs of the resident are not communicated to their plan of care, including the POC tasks, staff providing direct care to the resident are not aware of these needs or the requirement to provide them.

Sources: critical incident system (CIS) report, resident care plan, progress notes, and post fall assessments, and an interview with RPN and other staff. [s. 6. (2)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that resident's fall prevention and management device was used in accordance with manufacturers' instructions.

The resident was observed on an identified date and time, with a fall prevention and management device in place. A portion of this device was observed to be hanging and not secured, as required.

The resident's care plan and Point of Care (POC) task indicated to ensure this device was in place and functioning. POC documentation for this task on this date by a Personal Support Worker (PSW), indicated the device had been applied.

Documentation on this date and interviews with the PSW and DRC, indicated the resident had removed a portion of this device earlier in the day. Staff reapplied this portion of the device and later the same day, the resident again removed it as it had been within their reach.

Review of the manufacturers' directions for this device, indicated how to attach the device and to ensure it was out of the resident's reach.

The DRC confirmed the resident had independently removed the portion of the device. Review of the resident's care plan and POC tasks for this device indicated this task had been revised following the above incidents to indicate staff were to ensure the device, including the portion the resident removed, was applied to a specified location as the resident had a history of removing independently.

When this fall prevention and management device is not used in the home in accordance with manufacturers' instructions, there is potential for a resident to sustain harm as the device is not able to respond and alert staff in a timely manner.

Sources: Observations of a resident, resident care plan, POC documentation and progress notes, and an interview with PSW and other staff. [s. 23.]

Issued on this 24th day of August, 2021

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

Original report signed by the inspector.