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 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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 12, 2018	2018_739694_0012	015869-17, 020469-17, 003294-18, 007486-18	Critical Incident System

Licensee/Titulaire de permis

Corporation of the County of Dufferin
151 Centre Street SHELBURNE ON L9V 3R7

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

Dufferin Oaks
151 Centre Street SHELBURNE ON L9V 3R7

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): August 8, 9 and 10, 2018.

During the course of the inspection, the following Critical Incidents were inspected;
Log #015869-17 related to falls prevention
Log #007486-18 related to falls prevention
Log #003294-18 related to falls prevention
Log # 015869-17 related to falls prevention

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

During the inspection, the Long Term Care Homes Inspector toured the home, observed the provision of resident care, reviewed resident clinical records, personnel files, staff training records and relevant policies and procedures, and interviewed residents and staff.

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

During the course of this inspection, Non-Compliances were issued.
3 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	Legendé 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. (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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for the residents set out clear directions to staff and others who provide direct care to the resident.

Resident #003 had a number of falls in March 2018, was transferred to the hospital and diagnosed with a specific injury. The resident was assessed prior to the fall as a high risk for falls.

The clinical record was reviewed in March 2018 the resident sustained a number of falls, all of the post fall assessments completed that day had specific equipment/assistive device in place at the time of the fall. Resident #003's written plan of care, revised in April 2018, identified the resident was high risk for falls as evidenced by the quarterly fall risk assessment that was completed in December 2017 with recommendations to have a number of specific safety devices to be in place when the resident was up to prevent responsive behaviours. Not all safety devices were included on the written plan of care.

In an interview with a front line staff member they could not recall if the resident had a particular safety device. The DOC was also interviewed and confirmed the resident appeared to have a particular safety equipment in place on a certain day in March 2018 according to the Incident Report/ Post Fall Assessment documentation but there was no assessment or direction for the staff for the use of the particular safety device that could

be located. The DOC agreed the safety device should have been listed under fall risk and confirmed they were not on resident #003's written plan of care.

The licensee failed to ensure fall risk safety devices were on the written plan of care for the resident and set out clear directions for staff.

2. The licensee has failed to ensure that there was a written plan of care for each resident that set out, the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time the resident's care needs changed or care set out in the plan was no longer necessary.

Resident #003 had a number of falls in March 2018 that caused injury and the resident was transferred to hospital for further assessment the next day. Diagnostic tests confirmed an injury.

Based on the clinical record review an assessment was completed in March 2018, there had been no further reassessments completed for resident #003 after a number of falls that occurred in March 2018.

Resident #003 was transferred to hospital in March 2018 and returned to the home in April 2018. The written plan of care was updated in April 2018 and did not include information about an injury the resident had.

Long Term Care Homes (LTCH) inspector interviewed staff #106 in August 2018. Staff #106 was the staff member that completed the incident report/post fall assessment in March 2018 and documented the resident had a number of injuries. The DOC acknowledged this injury and stated the information was not included on the written plan of care that is available for direct care staff.

The licensee failed to ensure the plan of care was reviewed and revised when resident #003's care needs changed regarding skin integrity.

WN #2: 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. Where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system was (b) complied with.

In accordance with Regulation, s.48, required the licensee to ensure that the interdisciplinary programs including fall prevention, were developed and implemented in the home and each program must meet the requirements as set out in section 30. Each program must have a written description of the program that included its goals and objectives and relevant policies, procedures and protocols to meet the requirements as set out in section 30. O. Reg. 79/10, s.48

The licensee's policy "Fall Prevention and Management Program", directed nursing staff to complete an on-line incident report, which included assess the resident associated with the fall. Completion of an Incident Report/Post Fall assessment was to include contributing factors associated with the fall including the location, time and related activity and evaluate the plan of care.

A clinical record review of resident #003 was completed and on a certain day in March 2018 an incident report/post fall assessment form stated resident #003 had a specific number of falls that day. The location and circumstances for each of the falls was not noted.

In an interview with RN #109 acknowledged staff have been directed by management they may document multiple falls in one incident report and was unsure what the policy directed staff to do.

The licensee failed to ensure that when resident #003 had a fall, they were assessed and the contributing factors associated with each fall was included in the Incident Report/Post-Fall assessment according to the licensee's policy.

WN #3: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a Critical Incident Systems (CIS) report submitted to the Director included a description of the incident, including the type of incident , the area or location, the date and time of the incident and the events leading up to the incident.

A CIS report was submitted to the Director on a certain day in April 2018 regarding resident #003 who was taken to hospital that resulted in a significant change in the resident's health status. The report stated resident fell, was assessed for injuries and complained of pain. The report was not specific with a description of the incident including dates or times or events leading up to resident's transfer to hospital.

A record review of resident #003's incident reports/ post fall assessments revealed the resident had a number of falls, multiple falls were documented in one assessment, in March 2018.

The DOC was interviewed and acknowledged there was an altercation between resident #003 and #005 on a certain day in March 2018. The DOC did not include details of this incident that occurred on the same day in March 2018 as a number of falls had been reported on the CIS report. The DOC agreed it was not possible to determine the cause of resident #003's injury.

The licensee failed to ensure that a CIS report included a description of the incidents, area and location, date and time and events leading up to resident #003 being transferred to hospital and discovery of a specific injury.

Issued on this 3rd day of October, 2018

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

Original report signed by the inspector.