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
Apr 6, 2022	2022_876606_0008	017336-21, 017993-21, 019081-21, 002263-22	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

JANET GROUX (606)

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 28, March 1-4, 8, 9, and 11, 2022.

The following intakes were completed in this critical incident system (CIS) inspection:
Log #002263-22, log #019081, log#017993-21, and log #017336-21 related to the home's falls management program.

Note: This inspection was conducted concurrently with Complaint Inspection #2022_876606_0007.

During the course of the inspection, the inspector(s) spoke with the Unit Coordinators (UC), Falls Prevention Lead, Pain Management Lead, Facility Manager (FM), Physiotherapist (PT), Housekeeping staff, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers, and residents.

During the course of the inspection, the inspector observed resident and staff interactions, Infection prevention and control (IPAC) program, reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Pain

During the course of this inspection, Non-Compliances were issued.
- **4 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure different approaches to the plans of care of two residents were considered when interventions in place were not effective.

Two residents fell a number of times in 2021 and both sustained serious injuries during one of their falls. The residents plans of care did not identify any additional interventions or new approaches to address the residents' falls.

Two registered staff said when interventions in the plan of care were not effective, the care plan was reviewed and different strategies and interventions should be initiated to prevent further falls.

Failure to consider different approaches to to prevent and manage falls for two residents may have increased their falls risk.

Sources: Residents progress notes, care plans, incident/fall assessments, and interviews with staff.

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 if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care related to falls and prevention and management, to be implemented voluntarily.

WN #2: 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. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

The licensee has failed to ensure a falls intervention was readily available for a resident.

A resident was at high risk for falls and fell multiple times in 2021.

The resident had a falls interventions that was not working and a request for another one was initiated during the shift. The following shift, the resident fell and the resident's falls intervention did not work.

A manager said they were not able to replace the falls intervention because the maintenance department was not available.

Failure to have the required falls intervention readily available for the resident may have contributed to the resident's fall.

Sources: a resident progress notes, a work order, and an interview with staff.

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 equipments, supplies, devices and assistive aids are readily available in the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

A) A resident complained of pain which they stated was caused from a fall.

The home's pain management program directed registered staff to complete pain assessments when a resident had pain that was not relieved by initial interventions.

During an identified month in 2021, the resident's pain increased in frequency and in intensity. The staff said the resident displayed behaviours that indicated they were in significant pain.

On a number of occasions during the identified month, the resident was administered a medication to relieve their pain and the medication was ineffective. A clinically appropriate pain assessment was not conducted during the identified month when the resident's pain interventions were ineffective.

A registered staff said the home's pain assessment tool should have been completed when pain interventions were ineffective but this was not done.

B) A resident fell and sustained injuries from the fall. On two occasions, the resident was given medication for pain, however it was ineffective. A clinically appropriate pain assessment was not conducted during the identified month when the resident's pain interventions were ineffective.

A registered staff said when a resident's pain was not relieved from the pain medication, a pain assessment should be initiated and the doctor should be notified.

Failure to reassess pain for two residents when their current interventions were ineffective, prolonged the residents' pain and may have caused the residents further discomfort.

Sources: progress notes, care plans, medication administration records (MARs), the home’s pain policy and interviews with staff

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's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

The licensee has failed to ensure the falls prevention measures were documented for a resident.

A resident's falls management care plan directed staff to complete and document their specified falls prevention measures and to ensure falls interventions were functioning and in place.

A review of the clinical record for the resident did not show documentation that the falls prevention measures were implemented.

A registered staff said the home's direction was to implement the falls prevention measures and document after they had done so. The Falls Lead acknowledged this.

Sources: a resident's progress notes, identified clinical records and interviews with staff.

Issued on this 13th day of April, 2022

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

Original report signed by the inspector.