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
Nov 2, 2020	2020_834524_0023	020429-20	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the County of Elgin Municipal Homes
450 Sunset Drive 3rd Floor, Suite 303 ST. THOMAS ON N5R 5V1

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

Elgin Manor
39262 Fingal Line, R.R. #1 ST. THOMAS ON N5P 3S5

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

INA REYNOLDS (524)

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): October 27 and 28, 2020.

The following Critical Incident System (CIS) intake was completed within this inspection:
CIS #M518-000047-20 / Log #020429-20 related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Resident Care, the Resident Care Coordinator, a Registered Nurse, a Personal Support Worker and residents.

The inspector(s) also observed resident care provisions, resident and staff interactions, reviewed clinical healthcare records including assessments and care planning interventions for identified residents, and policies and procedures related to this inspection.

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

During the course of this inspection, Non-Compliances were issued.
- **3 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 :

1. The licensee has failed to ensure the home's falls prevention and management policy was complied with, for a resident.

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. Specifically, staff did not comply with the home's policies and procedures "Appendix B: Managing a Fall Post Fall Assessment and Management Algorithm".

The home's "Falls Prevention and Management" policy directed staff to initiate a head injury routine for all unwitnessed falls. Registered staff were to do the Head Injury Routine: every 30 minutes for two hours; every hour for four hours; every four hours for eight hours; and, every eight hours for the remainder of 72 hours.

Progress notes document a resident had fallen and was found on the floor, and head injury routine vitals were initiated. The progress notes further stated the resident was found again on the floor later in the day. The resident's Neurological Record for this second fall showed Head Injury Routine assessments were not always documented.

The Manager of Resident Care (MRC) acknowledged the missed intervals on the resident's record and said the expectation was that it should have been done as it was the home's policy. There was an increased risk to the resident related to Head Injury Routine assessments not documented.

Sources: "Falls Prevention and Management" policy (Revision Date: October 2019) and "Appendix B: Managing a Fall Post Fall Assessment and Management Algorithm"; the resident's progress notes, assessments, and paper chart; and, interviews with the MRC and other staff. [s. 8. (1) (a),s. 8. (1) (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 the home's falls prevention and management policy is complied with, for residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (1) Every licensee of a long-term care home shall ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home. O. Reg. 79/10, s. 24 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a 24-hour admission care plan was developed for a resident and communicated to direct care staff within 24 hours of admission of the resident's admission to the home.

A resident was newly admitted to the home. The South West Local Health Integration Network (LHIN) functional assessment documented that the resident required assistance with walking and transfers due to past falls and weakness; and, required assistance with personal care needs. The resident also had specific dietary requirements due to difficulties.

The admission progress notes documented that the resident required assistance with transfers, and personal care needs. The family had requested fall prevention equipment to be put in place. The progress notes documented that safety interventions and equipment had been placed in the resident's room and was connected to the nurse call system.

The resident's Admission Protocol Checklist directed registered staff to "Complete Admission 24 HR Plan of Care in PCC – once complete print off for PSW review". There was no documented evidence to support that a 24-hour admission care plan was developed for the resident and communicated to direct care staff within 24 hours of admission. A Registered Nurse (RN) acknowledged they were unable to find a 24-hour care plan in PointClickCare (PCC). The lack of a 24-hour admission care plan placed the resident at risk for improper care.

Sources: Critical Incident Report; South West LHIN Local Adult Functional Assessment; resident #001's clinical records; and, interviews with Registered Nurse, the Manager of Resident Care and other staff. [s. 24. (1)]

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 a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of admission of the resident's admission to the home, to be implemented voluntarily.

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. (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 :

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

A Critical Incident System (CIS) report was submitted to the Ministry of Long-Term Care (MLTC). The report indicated that a resident had unwitnessed falls in their bedroom and was hospitalized the next day for further assessment.

The resident's progress notes documented the day after the resident was hospitalized, a registered nurse had called the hospital for an update and was made aware that the resident's fall had caused an injury that resulted in a significant change in the resident's health condition.

The home's Falls Prevention policy stated that "if the resident is transferred to hospital resulting in a significant change in status and/or is admitted to the hospital, a MOHLTC critical incident report must be initiated by the Manager of Resident Care/designate."

The Manager of Resident Care (MRC) acknowledged that the home did not report the incident to the Director in a timely manner.

Sources: Critical Incident Report; resident's clinical records; the home's policy titled "Falls Prevention and Management" (Revision Date: October 2019); and, interview with the MRC and other staff. [s. 107. (3.1) (b)]

Issued on this 2nd day of November, 2020

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

Original report signed by the inspector.