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
Mar 31, 2022	2022_944480_0003	006994-21	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 Markham ON L3R 4T9

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

Extendicare Hamilton
90 Chedmac Drive Hamilton ON L9C 7S6

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

JENNIFER ALLEN (706480)

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): March 15-18, 21, 22, 2022.

The following intake was completed in this Critical Incident inspection:
Log # 006994-21, relating to falls.

Inspector #155 was present during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurse (RN), housekeeping and Personal Support Workers (PSWs).

During the course of the inspection, the inspector observed residents, their home areas and dining rooms, resident and staff interactions, and 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

During the course of this inspection, Non-Compliances were issued.
- **2 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 policies and procedures included in the required Falls Prevention Program were complied with for two residents.

O. Reg. 79/10, s. 30 (1) requires that the program at a minimum, provide for strategies to reduce or mitigate falls that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes.

O. Reg. 79/10, s 48 (1) requires that interdisciplinary programs are developed and implemented in the home including a falls prevention and management program to reduce the incidence of falls and the risk of injury.

Specifically, the staff did not comply with the home's policy and procedure for monitoring a resident following a fall with possible injuries.

The home's Fall Prevention and Management Program provided a clinical tool that provided direction for clinical decision making for the staff, displaying that if a resident sustained a fall, then the staff should proceed to complete the specific documentation and assessments, which stipulated the required time intervals for monitoring the resident.

A. A resident sustained a fall. The staff failed to complete the required documentation for monitoring the resident. These mandatory assessments was required to be completed at specified times for monitoring the resident, some of these assessments were not completed.

The home's policy stated the staff should implement the specific documentation and monitor the resident whenever a resident sustained a fall with possible injuries. The staff was expected to assess the resident at specified times until further direction from the physician.

A staff member stated following a resident's fall a series of assessments was required and could be initiated by checking a box on the online assessment form and the nursing progress note would automatically be populated into the resident's chart. The staff member also stated that in order to complete the required documentation following a fall with possible injuries all assessments were required to be completed over a specified time duration as stipulated by the home's policy.

The DOC stated that all falls, meeting the home's policy parameters, should have the falls documentation and assessments completed and should be started right way at the time of the fall, then completed over the required time interval.

Sources: Point Click Care Online documentation and progress notes, The Neurological Signs/Head Injury Routine Policy (Last reviewed December 2019); The Fall Prevention and Management Program (Last reviewed December 2020); Post Fall Clinical Pathway (Last updated December 2020); Interview with the DOC and staff.

B. A second resident sustained a fall. The staff following a fall with possible injuries were required to complete specific documentation and assessments. However, there were several missing assessments identified. The first four required assessments were not completed. The 1800 hour assessment was not completed, and an assessment that was documented was incomplete.

The timing between the assessments were not completed consistently with the required time intervals as per the home's policy. Between shift assessment three and shift assessment four there was a 16 hour gap, between shift assessment four and shift assessment five there was a nine hour gap, and between shift seven and shift eight assessment there was a ten hour gap.

The home's policy stated the staff was expected to assess the resident at the specified time intervals, until further direction from a physician.

The missing assessments for the two residents may have increased the risk of potential

delay in identifying injuries and complications.

Sources: Point Click Care Online documentation and progress notes, The Neurological Signs/Head Injury Routine Policy (Last reviewed January 2022); The Fall Prevention and Management Program (Last reviewed December 2020); Post Fall Clinical Pathway (Last updated December 2020); Interview with the DOC and staff.
[s. 8. (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 the policy for neurological clinical monitoring of a resident for a unwitnessed fall is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the Infection Prevention and Control Program when staff did not perform Hand Hygiene (HH) for the residents when leaving the dining room and when providing snacks.

During a dining room meal observation, it was observed the staff did not offer or provide hand hygiene to the residents when leaving the dining room after their meals. During a second dining room meal observation, two residents were observed to exit the dining room without staff offering or providing hand hygiene. During a third dining room meal observation it was observed that three residents exited the dining room without staff offering or providing hand hygiene.

During a snack pass observation, it was observed that the staff brought snack to six resident rooms and did not offer or provide hand hygiene to their residents.

The staff member stated that they did not provide hand hygiene for the residents during snack distribution and acknowledged that they were trained to use hand sanitizer for hand hygiene for the resident's hands.

The ADOC confirmed it’s the home's expectation that staff were to assist the residents with their hand hygiene after meals.

The Hand Hygiene Policy, stated the residents should be encouraged and/or offered assistance to properly wash or sanitize their hands regularly, including before and after meals and snacks.

Failure to participate in the Infection Prevention and Control Program presented a minimal risk to residents related to the possible ingestion of disease-causing organisms that may have been on their hands.

Sources: Observation of dining rooms and snack distribution; The Hand Hygiene Policy (Last review June 2021); interview with the ADOC and staff.
[s. 229. (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 all staff participate in the implementation of the program, to be implemented voluntarily.

Issued on this 4th day of April, 2022

[redacted]

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

Original report signed by the inspector.