Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue 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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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 1, 2019	2019_729615_0017	002388-19, 002703-19, 002704-19	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 Port Stanley
4551 East Road PORT STANLEY ON N5L 1J6

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

HELENE DESABRAIS (615), AMBERLY COWPERTHWAITE (435)

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 25 and 26, 2019.

The following Critical Incident (CI) report was inspected during the course of this inspection:
CI #2669-000002-19/Log #002388-19 related to prevention of falls, and;
Follow-up Order #001 from inspection #2019_722630_0003 related to non-compliance to policy to promote zero tolerance of abuse and neglect of residents;
Follow-up Order #002 from inspection #2019_722630_0003 related to non-compliance to ensure that all staff at the home have received training before they perform their responsibilities.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, one Registered Nurse (RN), two Registered Practical Nurses (RPNs) and two Personal Support Workers (PSWs).

During the course of the inspection, the inspector(s) also reviewed medical records for the identified residents, review the home's internal investigations notes, policies and procedures and other relevant documents.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #001	2019_722630_0003	615
LTCHA, 2007 S.O. 2007, c.8 s. 76.	CO #002	2019_722630_0003	615

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. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure a plan of care was based on, at a minimum,

interdisciplinary assessment of residents' health conditions, including allergies, pain, risk of falls and other special needs.

Critical Incident System (CIS) report # 2669-000002-19 was first submitted to the Ministry of Health and Long-Term Care (MOHLTC) and outlined an incident in which a resident sustained a fall, had a significant change in condition and was sent to hospital for assessment.

A review of the progress note on a specific date, stated in part, that the resident had been found in an area of the home to have sustained a fall and upon assessment by staff member, new pain was indicated and Emergency Medical Service (EMS) was called, and the resident was sent to hospital and was readmitted to the home at a later date.

A review of the resident's Scott Fall Risk Screen assessments in PointClickCare (PCC) before the fall noted that resident had the universal fall precautions in the home. The next Scott Fall Risk Screen assessment for the resident #001's upon return from the hospital indicated that the resident was at a high risk for falls.

A review of the resident's care plan at the time of the fall, indicated no focus related to fall risk or interventions to reduce the occurrence of falls and the current care plan indicated a Scott Fall Risk score of high risks for falls was initiated approximately a month later.

A review of the home's policy #RC-15-01-01 "Falls Prevention and Management Program" last updated February 2017, stated in part "Procedures: Screen all residents on admission, annually, with a change in condition that could potentially increase the resident's risk of falls/fall injury, or after a serious fall injury or multiple falls (if not already a high risk)".

A review of the home's "Re-Admission Checklist" updated November 22, 2018, stated in part "Checklist #2 – complete if resident was admitted to hospital. Task: Complete Falls Management – Scott Fall Risk Screen if the resident was sent to hospital based on a fall or they have had a significant change in status overall. Update Care Plan and make sure that ALL areas are reflective of change".

During an interview, Registered Nurse (RN) when asked when they would expect the resident to be assessed for fall risk, the RN stated that they would expect the charge staff to immediately assess the resident when they returned from the hospital as the resident health condition had totally changed when they returned and expected this to be

documented under a Scott Fall Risk Assessment and in a progress note.

During an interview, the Fall Lead Registered Practical Nurse (RPN) stated that a fall risk assessment was supposed to be evaluated with a significant change in a resident and they would expect this to be completed after a fall occurs and within 24 hours after a resident was readmitted from the hospital. When asked if a fall risk assessment had been completed for the resident when they returned from the hospital, the RPN stated that there was no fall risk assessment completed for this resident after their return from hospital and stated that it should have been completed. The RPN stated that the resident should have also received a fracture risk assessment when they returned from the hospital as upon resident's return to the home as they would have been a high risk for fracture. When asked if there was anything in the resident's care plan related to falls risk and interventions between the time the resident returned from hospital and the following month, the RPN stated that there was no care plan related to falls risk or interventions to reduce falls for the resident and that the resident's fall risk assessment and fall prevention strategies had fell through the cracks for this time period.

The licensee has failed to ensure that the resident's plan of care was based on an interdisciplinary assessment of their risk of falls when the resident was not re-assessed for their fall risk upon their return from hospital and was reassessed approximately a month later. [s. 26. (3) 10.]

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 a plan of care is based on, at a minimum, interdisciplinary assessment of residents' health conditions, including allergies, pain, risk of falls and other special needs, to be implemented voluntarily.

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Issued on this 1st day of April, 2019

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

Original report signed by the inspector.