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
Jan 27, 2020	2020_792659_0002	023995-19	Critical Incident System

Licensee/Titulaire de permis

peopleCare Communities Inc.
735 Bridge Street West WATERLOO ON N2V 2H1

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

peopleCare Hilltop Manor Cambridge
42 Elliott Street CAMBRIDGE ON N1R 2J2

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

JANETM EVANS (659)

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): January 21, 22 and 23, 2020.

The following intake was included in this inspection:
Log #: 023995-19\AH IL-73063-AH\CI 2606-000021-19 related to an unexpected death of a resident.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Executive Director of Nursing (EDON), Directors of Resident Care (DRC), Director of Food Services (DFS), Assistance Director of Food Services (ADFS), Staffing Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

Observations were completed of general care and appearance of residents. Review of relevant documentation was completed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition

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)**

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 that where the Act or this Regulation required the licensee of a long term care home to have, institute or other wise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 48 (1) 1 and in reference to O. Reg. 79/10, s. 49 (1) the licensee was required to ensure the falls prevention and management program must, at a minimum provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipments, supplies, devices and assistive aids.

Specifically, staff did not comply with the licensee’s policy #005200, regarding head injury routine (HIR), last revised September 16, 2019, which is part of the licensee's Fall Prevention and Management Program - Falls Risk Factors and Related Interventions, #005190.00.

The licensee's policy related to HIR said that the "HIR must be completed for any resident who receives a blow to the head either from a fall (including all unwitnessed fall) or personal injury". The head injury check was to include:
-vital signs
-right and left eye movement, including pupil size and reaction
-motor response
-level of consciousness
-medication
-comment .i.e. history of Cerebral Vascular Accident, neurological deficit, amputations

A Critical Incident was submitted to the Ministry of Long Term Care (MLTC) December

21, 2019, related to the unexpected death of resident #001.

(A) Resident #001 had a history of falls. A physiotherapy note documented resident #001 had been assessed as high risk for falls.

On a specified date, resident #001 was in their room, when they sustained an unwitnessed fall with injury. They were transferred to hospital for assessment and later returned to the home.

A head injury routine (HIR) assessment was initiated for the resident upon their return from hospital. RN #116 documented over a five hour period on the HIR that the resident's pupil response for both eyes was reactive, but pupil size was not documented. The remainder of the documentation on the HIR indicated that staff were prevented from completing an assessment of the resident's left eye due to an injury. The right pupil response was recorded, but not the pupil size. A progress note documented that the resident's left eye could not be assessed due to the injury.

RN #108 said that normally they would document the pupil size as part of the neurologic assessment post fall.

(B) Resident #002 had a history of falls. Their clinical record showed they had eight falls in the last six months. Two Fall Risk Screening and post fall assessments reviewed documented that the resident was at high risk for falls.

On a specified date, resident #002 had an unwitnessed fall in their room. The resident's clinical records did not show evidence that a HIR was completed for this fall.

On a second specified date, resident #002 had a fall in their room. A HIR was initiated, however blanks were left in the documentation on five instances and on two instances it was documented the resident was at a meal and no HIR was completed. Where entries had been made for the neurological assessment no pupil size had been documented.

DRC #111 reviewed the resident's chart and acknowledged there was no HIR documented for one of the resident's falls. The DRC said they would have expected a HIR was completed for this fall. The DRC reviewed the HIR completed for the resident's second fall and acknowledged pupil size had not been documented on this record and that blanks had been left in the documentation.

(C) Resident #003 had a history of falls. A Fall Risk Screening and Post Fall assessment on two specified dates documented the resident as high risk for falls.

On one specified date resident #003 sustained an unwitnessed fall in their bathroom. The resident's clinical records did not show evidence that a HIR was completed for this fall.

On the second specified date, resident #003 sustained an unwitnessed fall in their room. A HIR was initiated for this fall, however, on seven instances blanks were left in the documentation and the resident's pupil size was not documented as part of neurological assessment.

DRC #111 reviewed the resident's chart and acknowledged that a HIR had not been completed for the one of the falls. DRC #111 reviewed the HIR completed for a second fall and acknowledged pupil size had not been documented on this record and blanks had been left in the documentation.

EDON #100 and DRC/Falls Lead #112 stated that a HIR should be completed for all unwitnessed falls and that pupil size should be documented as part of the neurological assessment. They acknowledged that the HIR for the three residents had not been completed in accordance with the home's policy related to HIR.

The licensee had failed to ensure that any policy instituted or otherwise put in place was complied with. Specifically, staff did not comply with the licensee's policy regarding Head injury routine (HIR), last revised September 16, 2019. [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 that in accordance with the home's policy, a HIR is completed for for resident #002 and #003 and all other residents who have unwitnessed falls and that as part of the neurological assessment, the size of the resident's pupils will be noted and documented, to be implemented voluntarily.

Issued on this 4th day of February, 2020

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

Original report signed by the inspector.