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 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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 11, 2018	2018_760527_0019	023288-18, 024744-18, 024745-18	Critical Incident System

Licensee/Titulaire de permis

2063412 Ontario Limited as General Partner of 2063412 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Creedan Valley Care Community
143 Mary Street CREEMORE ON L0M 1G0

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

KATHLEEN MILLAR (527)

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): August 31, September 4, 5 and 6, 2018

The following Critical Incidents were inspected:

Log #023288-18, related to falls;
Log #024744-18, related to falls; and
Log #024745-18, related to falls

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC)/Resident Assessment Instrument (RAI) Coordinator, the Nurse Practitioner (NP), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Care Support Assistants (CSAs), Physiotherapist (PT), physiotherapy aide (PTA), maintenance staff,
residents and family members.

During the course of the inspection, the inspector toured the home, observed the provision of care and services, reviewed relevant documents, including but not limited to, clinical
records, policies and procedures, internal investigation notes and training records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Pain

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 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	Legendé 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that sets out, (c) clear directions to staff and others who provided direct care to the resident.

Resident #001 had a fall on a specific date in 2018. The Director of Care (DOC) contacted the Nurse Practitioner (NP). The NP ordered specific interventions and the Physiotherapist (PT) was consulted and a mobility device was implemented.

The clinical record review was completed and on the written plan of care there was a notation, which identified specific interventions; however there were no instructions to assist staff with implementing the interventions and the monitoring required.

PSW #112 was interviewed and they explained the interventions implemented for resident #001. The PSW said that the written plan of care was not clear as to what they had to do and how often they could remove the mobility device to provide care and perform assessments.

PT #113 was interviewed and acknowledged they had applied a device and had trained the staff that they could remove it for personal care and to assess the resident. The PT said the device was expected to be on all the time, except for care.

The licensee failed to ensure that there was a written plan of care for resident #001 that sets out, (c) clear directions to staff and others who provided direct care to the resident.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #023288-18.

2. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

Resident #001 had a fall on a specific date in 2018. The resident required further treatment and was experiencing a change in status as a result of the fall.

The clinical record was reviewed and identified in the Point of Care (POC) notes that on specific dates in 2018, the PSW documented in their assessment that the resident had changes. There was no communication to the registered staff and no assessments completed by the registered staff.

PSW #112 and #113 were interviewed individually and said that they were expected to document their resident's checks in POC and notify the charge nurse if there were any changes; however they could not recall if they communicated any changes regarding resident #001's condition to the charge nurse.

RPN #110 was interviewed and said that usually when the PSWs identify any changes in the resident's condition, they notify the charge nurse; however they were unable to recall if any of the PSWs had reported any changes in the resident's condition.

The DOC was interviewed and acknowledged that the PSW's were expected to notify the charge nurse of any resident changes to the registered staff, which should have resulted in the registered staff completing a further assessment.

The licensee failed to ensure that the staff and others involved in the different aspects of

care of resident #001, collaborated with each other, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #023288-18.

3. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #001 fell on a specific date in 2018. The physician ordered a diagnostic test as they continued to have symptoms.

The clinical record was reviewed and revealed that when the DOC notified the NP of resident #001's change in condition, the NP ordered interventions to be implemented. The Medication Administration Record (MAR) and the Treatment Administration Record (TAR) were reviewed and the medication and treatments were not implemented until two days after they were ordered.

The DOC was interviewed and acknowledged that they had taken a telephone order from the NP and said they expected the medication and treatment to be implemented by the registered staff on the same day as the NP's ordered them.

The licensee failed to ensure that the care set out in the plan of care for resident #001 was provided to the resident as specified in the plan.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #023288-18.

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 there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident; to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and to ensure that the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was: (b) complied with.

A) Resident #001 had an unwitnessed fall on a specific date in 2018. The resident was assessed by RN #104 and the post fall assessment and head injury routine (HIR) were initiated.

(i) The licensee's policy titled "Falls Prevention", directed registered staff to complete the electronic post fall assessment using the Post Fall Huddle or Fall Incident Report. This

post-fall assessment tool was a clinically appropriate assessment instrument that was specifically designed for falls.

The clinical record was reviewed, which identified that the Post Fall Incident Form was initiated; however it was incomplete.

(ii) The licensee's policy titled "Head Injury Routine", directed registered staff to ensure HIR was initiated on any resident who had sustained or was suspected of sustaining a head injury; and after any unwitnessed resident fall. Registered staff were to complete the HIR as per the schedule outlined or as ordered by the Physician. The policy also directed registered staff to complete the Falls Risk Assessment in the electronic documentation system when the resident had a significant change in status.

The clinical record was reviewed, which identified the resident had the HIR initiated and it was not being performed according to the licensee's schedule noted on the HIR tool. The Inspector was unable to find a recent Falls Risk Assessment.

RN #104 and RPN #110 were interviewed individually. Both registered staff acknowledged that they were expected to complete a post fall assessment using the clinically appropriate tool designed for falls in point click care and complete the HIR as outlined in the schedule.

B) Resident #002 had an unwitnessed fall on a specific date in 2018. The resident was assessed by RN #107 and the head injury routine (HIR) was initiated.

The clinical record was reviewed, which identified the HIR was initiated for this resident and was not being performed according to the licensee's schedule noted on the HIR tool.

RN #107 was interviewed and acknowledged that according to their policy and procedures they were expected to perform HIR on residents, when they had an unwitnessed fall or if any resident fell and hit their head.

The DOC was interviewed and acknowledged that registered staff were expected to complete head injury routine for resident #001 and #002 for 72 hours after the incident and according to their HIR schedule and this was not done. The DOC also acknowledged that registered staff were expected to complete the post fall assessment for resident #001, according to their policies and procedures.

The licensee failed to ensure that the Falls Prevention and Head Injury Routine policy and procedures were complied with.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #023288-18.

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 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, (b) is complied with., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a PASD described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

Resident #001 was assessed as needing a mobility device. The resident was using the mobility device for comfort and positioning.

The clinical record was reviewed and the Personal Assistive Services Device (PASD), specifically the resident's mobility device, was not included in the resident's written plan of care.

PSW #105 and #109 were interviewed individually and they were unable to locate the PASD in the resident's written plan of care, but said that the resident had used a mobility device on a daily basis for comfort and positioning.

The DOC was interviewed and acknowledged the resident used a PASD for activities of daily living, specifically for comfort and positioning and that it should have been in the written plan of care. The DOC said they had consent from the resident's substitute decision maker, to ensure the resident continued to need the mobility device/PASD and the resident was monitored closely when using the mobility device.

The licensee failed to ensure that a PASD described in subsection (1) was used to assist resident #001, with a routine activity of living was included in the resident's plan of care.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #023288-18.

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 PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care, to be implemented voluntarily.

WN #4: 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 :

1. The licensee failed to ensure that when a resident’s pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Resident #001 was administered specific medication, which was effective.

The licensee's policy titled “Pain & Symptom Management”, directed registered staff to screen for the presence of pain and complete a pain assessment electronically for specific pain scores and when the resident reported or exhibited signs and symptoms of pain for a specific period of time.

The clinical record was reviewed and revealed that during a specific time period, the resident's pain score had increased and the resident exhibited signs and symptoms of pain for a specific time period; however there was no pain assessment completed using a clinically appropriate assessment instrument specifically designed for pain.

RPN #110 was interviewed and was not aware that they were expected to complete the pain assessment using a clinically appropriate assessment instrument specifically designed for pain in Point Click Care (PCC) for specific pain scores and/or when the resident's pain continued for a specific time period after they were administered medications and/or when their treatment was implemented.

The DOC was interviewed and acknowledged that registered staff were expected to complete a pain assessment electronically in PCC for specific pain scores and/or when the resident reported or exhibited signs and symptoms of pain for a specific time period, following implementation of pharmacological and/or non-pharmacological interventions.

The licensee failed to ensure that when resident #001's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

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 #5: 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 :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including interventions were documented.

Resident #001 had a fall on a specific date in 2018 and was injured. The plan of care was reviewed and identified the PSWs were expected to perform and document their checks, monitor and reposition the resident.

The licensee's policy titled "Documentation - Resident Record", directed the PSWs to record electronically all pertinent resident care delivery information prior to the end of their shift on the resident's individual record and report any change in status or condition in any regard to registered staff immediately and repeat this report at the time of change of shift report.

The Point of Care (POC) documentation for checks and repositioning were reviewed. There was inconsistent documentation related to checks, monitoring and repositioning for resident #001.

PSW #105 and #109 were interviewed individually and acknowledged that they were expected to document the checks and monitoring and repositioning of resident #001 in the POC notes. Both PSWs acknowledged that if they observe anything abnormal with the resident, they were expected to report that to the charge nurse so they can do their assessment.

The DOC was interviewed and acknowledged that the PSWs were expected to document their checks and care provided to residents in the POC and if they identify any changes in the resident's condition, they were to report to the charge nurse.

The licensee failed to ensure that any actions taken with respect to resident #001, under a program, including interventions were documented.

This area of non-compliance was identified during a Critical Incident Inspection, log #023288-18.

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Ministère de la Santé et des Soins de longue durée

Rapport d’inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 16th day of October, 2018

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

Original report signed by the inspector.