Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 17, 2019	2019_779641_0025	017253-19	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Hallowell House
13628 Loyalist Parkway PICTON ON K0K 2T0

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

CATHI KERR (641)

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): September 6, 10 and 11, 2019.

This inspection was conducted in reference to intake #017253-19, CIS #0891-000018 -19 related to a resident falling and sustaining an injury.

During the course of the inspection, the inspector(s) spoke with the Acting Executive Director, the Director of Care, the Regional Clinical Manager, Registered Nurses, Registered Practical Nurses, Personal Support Workers, and the resident.

During the course of the inspection, the Inspector reviewed resident care and services, observed staff to resident interactions, reviewed resident health care records and Critical Incident System reports (CIS) and relevant licensee investigation notes and policies and procedures related to falls prevention.

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

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

- **1 WN(s)**
- **0 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001 was reassessed and the plan of care revised when the resident's care needs changed.

During the evening of a specified date, resident #001 had fallen sustaining an injury. The Inspector reviewed the resident's health care record on the morning of September 6, 2019, which documented that at the time of the fall, the resident had been assessed as a low risk for falls. The resident had no falls since admission, two years prior to the time of this incident, until two days before the incident. The resident sustained a fall on a specified date, two days before the incident with injury, and another fall the morning of the incident, neither resulting in an injury. The resident's plan of care had not been updated since the resident had sustained the three falls. The resident's plan of care indicated that the resident was independent with transfers and mobility.

During interviews with Inspector #641 on September 6, 2019 at 1410 hours, PSW #101, #102 and #103 advised the Inspector as to the current status of resident #001. PSW #101 advised that the resident did have three falls recently but prior to that, the resident was mobilizing without any assistance from the staff. PSW #102 stated that the resident had not been feeling well during the last few days and had been unsteady walking independently. On the day of the interview, PSW #102 specified that the resident had required two staff to pivot transfer the resident onto the commode. PSW #101 advised that the resident didn't have any specific falls prevention interventions in place. PSW #101 stated that if the resident had to go to the washroom, the resident would not normally ring the call bell, but would usually just get out of bed without assistance.

During an interview with Inspector #641 on September 10, 2019, RN #108 stated that resident #001 wasn't strong enough to mobilize with the walker since the fall with injury. The RN advised that the resident was now using a wheelchair for mobilizing throughout the unit. The RN indicated that they hadn't instituted any new interventions for falls prevention as resident #001 was very fearful of falling and wouldn't get up independently. The RN stated that if there were some specific strategy that a resident should be using for falls prevention, the registered staff could implement this on their own immediately. The RN advised that when there was a change in health status, such as resident #001 now being unsteady and using a wheelchair, this would be updated in the resident's plan of care at the time it was implemented.

Inspector #641 reviewed the resident's health care record. Prior to the fall on the

specified date, the resident had mobilized independently and was self-sufficient with most ADLs, needing setup help only. After the fall on the specified date, causing the injury, the resident required extensive assistance from staff requiring the assistance of one to two staff as indicated by the staff interviewed and the point of care documentation. The resident's care plan had not been updated 1.5 days after the resident had stabilized after the third fall.

The licensee failed to ensure that resident #001 was reassessed and the plan of care revised when the resident's care needs changed. [s. 6. (10) (b)]

Issued on this 17th day of September, 2019

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

Original report signed by the inspector.