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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
May 14, 2019	2019_532590_0015	009318-18, 009610-18, 014959-18, 018387-18, 019529-18, 024382-18, 005578-19	Critical Incident System

Licensee/Titulaire de permis

St. Peter's Care Centres
125 Redfern Avenue HAMILTON ON L9C 7W9

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

St. Peter's Residence at Chedoke
125 Redfern Avenue HAMILTON ON L9C 7W9

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

ALICIA MARLATT (590), CHRISTINA LEGOUFFE (730)

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): May 6 - 10, 2019.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, two Resident Care Supervisors, two Registered Nurses, five Registered Practical Nurses and five Personal Support Workers.

During the course of the inspection, the inspector(s) observed infection prevention and control practices, medication storage areas, staff and resident interactions, resident home areas and the general maintenance and cleanliness of the home.

During the inspection, the inspector(s) reviewed residents' clinical records, Critical Incident System reports, meeting minutes, relevant policies and procedures related to inspection topics, incident reports, internal investigation notes and employee records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date. This CIS report was submitted under the Mandatory Report category "Improper/Incompetent treatment of a resident that results in harm or risk to a resident." The CIS report stated that on a specified date, resident #001 sustained a fall off of their bed after they were left unattended with their bed in an elevated position. Personal Support Worker (PSW) #111 had repositioned resident #001 by themselves, so that the Registered Practical Nurse (RPN) could administer a medication. When the RPN went into resident #001's room a few moments later they found them on the floor beside the bed. This fall resulted in multiple red abrasions to the resident's skin.

PSW's #106 and #107 stated that they could look on Point of Care (POC) to find information related to a resident's care needs.

A review of resident #001's plan of care showed, an intervention, which stated "Bed in lowest position." This intervention was initiated prior to the fall out of bed. The plan of care also had an Activities of Daily Living (ADL) Function focus, with an intervention, which stated "ADL - BED MOBILITY - Requires total assistance of two staff with all aspects of bed mobility." This intervention was also initiated prior to the fall out of bed.

Resident Care Supervisor (RCS) #100 stated, during an interview, that PSW #111 did not follow resident #001's plan of care when they left the resident unattended with the bed in an elevated position. RCS #100 said that PSW #111 received discipline related to this incident and provided inspector #730 with a copy of the written discipline letter. The written discipline letter outlined that PSW #111 had not followed the plan of care for resident #001 when they repositioned the resident on their own, and left the resident unattended in a vulnerable position.

The licensee had failed to ensure that the care set out in the plan of care, related to bed mobility and falls prevention, was provided to resident #001, as specified in the plan. [s. 6. (7)]

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 care set out in the plan of care is provided to resident #001 as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that the Director was immediately informed of a suspicion of improper or incompetent care, which resulted in harm to the resident.

The home submitted a CIS report to the MOHLTC on a specific date. This CIS report was submitted under the Mandatory Report category "Improper/Incompetent treatment of a resident that results in harm or risk to a resident." The CIS report stated that two days prior, resident #001 sustained a fall off of their bed after they were left unattended with their bed in an elevated position. PSW #111 had repositioned resident #001, so that the RPN could administer a medication. When the RPN went into resident #001's room a few moments later they found them on the floor beside the bed. This fall resulted in multiple red abrasions to the resident's skin.

During an interview with Resident Care Supervisor (RCS) #100, they stated that they were familiar with the MOHLTC reporting requirements. They stated that it would be their expectation that the incident would have been reported to the MOHLTC immediately. RCS #100 stated that the CIS report was submitted late to the MOHLTC, and that the CIS report should have been initiated as soon as management was made aware of the situation. They stated that staff were expected to inform management as soon as possible of an allegation of improper or incompetent care. They stated that they were not certain when management was informed of the situation, but management had been informed at least the day before the CIS was submitted, as their investigation notes related to the incident were dated the day prior to the report. The CIS report was not submitted by the home until two days after the fall.

The licensee had failed to ensure that the Director was immediately informed of a suspicion of improper or incompetent care of resident #001, which resulted in harm to the resident. [s. 24. (1) 1.]

WN #3: 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 had failed to ensure that any actions taken with respect to a resident under a program, including assessments, were documented.

Ontario Regulation 79/10 s. 48 (1) states "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: a falls prevention and management program to reduce the incidence of falls and the risk of injury."

Ontario Regulation 79/10 s. 49 (2) states "Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls."

The home submitted a CIS report to the MOHLTC, on a specified date. The CIS report stated that resident #003 had an unwitnessed fall on a specific date. The resident was sent to hospital and was found to have a non-displaced fracture.

A post-fall assessment completed on the day of the fall, stated there was no serious injury noted upon assessment and a head injury routine (HIR) was initiated.

A progress note titled "Post Fall Follow Up Data", for resident #003, dated the day after the fall, stated "NVS (neurovital signs) continue as per post fall protocol. No apparent injuries noted from fall and no abnormalities noted on VS (vital signs). Days to continue as per protocol."

The home's policy titled "Falls Prevention and Post Fall Management Program," with a revised/reviewed date of August, 2017, stated under section "Resident Fall Event" "5. If the fall was un-witnessed, or a Resident has hit their head, a head injury routine/Neuro-

vital assessment will be initiated."

The home's policy titled "Head Injury Routine" with a reviewed date of February, 2017, stated under Procedure to "document all findings on the Neurological Assessment Record."

During an interview on May 7, 2019, with RPN #108, they stated that HIRs' were initiated after a fall if the fall was un-witnessed and the resident was cognitively impaired or a head injury was suspected.

Inspector #730 reviewed the paper chart for resident #003 and was unable to locate the Neurological Assessment Record for the fall.

During an interview with RCS #100, they stated that they would expect that a HIR would have been initiated. They stated that since it was documented in the progress notes that a HIR was initiated they would expect that it was initiated, but they did not know where the documentation record was. They stated that as the resident was deceased, if it was not in the resident's paper chart then the home did not have the completed Neurological Assessment Record.

The licensee had failed to ensure that any actions taken with respect to resident #003, under the falls prevention and management program, including assessments, were documented. [s. 30. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee had failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

A CIS report was submitted to the MOHLTC on May 11, 2018. The home had reported that they discovered a missing controlled substance, specifically one Hydromorphone ampoule for resident #011. Further review of the CIS report showed that the homes' Pharmacist had discovered the missing medication while completing drug destruction on May 4, 2018.

In an interview with the Administrator #116 and Director of Care #115, they shared that they were aware of the mandatory reporting requirements, however could not speak as to the reason for the late reporting as they had not been in their current positions at the time of the incident. They acknowledged that the home had not reported this incident within one business day as outlined by legislation. [s. 107. (3) 3.]

Issued on this 14th day of May, 2019

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

Original report signed by the inspector.