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
Aug 6, 2020	2020_803748_0004	023885-19, 000860-20	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of Halton
1151 Bronte Road OAKVILLE ON L6M 3L1

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

Creek Way Village
5200 Corporate Drive BURLINGTON ON L7L 7G7

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

EMMY HARTMANN (748)

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): June 19, July 17, 20, 21, 22, 23, 27, 28, 2020

The following intake was completed in this Critical Incident Inspection (CIS):

Log #023885-19, Critical Incident System (CIS) #M623-000020-19 was related to a fall that resulted in a transfer to hospital.
Log #000860-20, was related to a follow-up inspection to compliance order #001, regarding Ontario Regulation 79/10 section 8. (1), with a compliance due date of January 30, 2020.

During the course of the inspection, the inspector(s) spoke with residents, the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Manager of Care, registered nurses (RN), registered practical nurses (RPN), and personal support workers (PSW).

During the course of the inspection, the inspector also observed the provision of care and services, and reviewed records, and policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

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
O.Reg 79/10 s. 8. (1)	CO #001	2019_695156_0006	748

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

Log #023885-19, Critical Incident System (CIS) #M623-000020-19 was reported to the MLTC related to an incident that caused an injury for which a resident was transferred to the hospital and to which resulted in a significant change in the resident's health status.

A review of the home's risk management record for resident #001's fall on an identified date, indicated that it was reported to the nurse that the resident was on the floor at an identified time. The resident was noted to have sustained an injury, as a result of the fall. The resident's Power of Attorney (POA) was notified and the physician came in to assess the resident. After a discussion between the resident's POA and the physician, the resident was transferred to the hospital for further assessment. The resident was noted to have returned from the hospital on an identified date and time.

During a review of resident #001's records, it was identified that the resident was assessed to be at risk for falls on their Falls Risk Assessment (Morse). It was also identified that resident #001 had a cognitive impairment, and that they exhibited responsive behaviours. Resident #001 had several interventions in place to manage their behaviours; and received a specific intervention to assist in monitoring their safety.

During an interview with RPN #103, they identified that following resident #001's transfer to the hospital after their fall on an identified date, the resident returned to the home with no further injuries identified. They indicated that at that time, resident #001 was supposed to have a specific intervention in place to monitor their safety. RPN #103 identified that they worked on the unit on the date of the resident's fall, and that the specific intervention was not in place when the resident fell. They identified that resident #001's plan of care was not followed.

During an interview with Manager of Care #104, they confirmed that resident #001 was supposed to have a specific intervention in place to monitor their safety. However, they confirmed that resident #001's plan of care was not followed when the resident fell on an identified date and time.

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 the resident as specified in the plan, to be implemented voluntarily.

Issued on this 6th day of August, 2020

[redacted]

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

Original report signed by the inspector.