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
Jul 14, 2021	2021_689586_0020	017101-20, 021309-20, 004980-21	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

JESSICA PALADINO (586)

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 24, 25, 29, 30 and July 6-9, 2021.

Inspectors #916 and #926 were present and shadowing during the inspection.

The following Critical Incident System (CIS) inspections were conducted concurrently:
004980-21 (CIS# M623-000005-21), 021309-20 (CIS# M623-000012-20) and 017101-20 (CIS# M623-000010-20) related to fall prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator, Senior Nursing Manager (SNM), Managers of Resident Care (MoRC), Physiotherapist (PT), maintenance staff, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW) and families.

During the course of the inspection, the inspector(s) completed an infection prevention and control (IPAC) checklist, observed resident care and reviewed resident health records, relevant policies and procedures, maintenance logs and program evaluations.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Minimizing of Restraining
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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 the home's fall prevention policy was complied with.

In accordance with O. Reg 79/10, s. 30 (1) 1, the licensee is required to develop relevant policies, procedures and protocols for each of the interdisciplinary programs as required under section 48 of the Regulation; specifically, s. 49, fall prevention and management.

A. The licensee's policy, 'Post Fall Follow up, Assessment & Management', with addendum 'Falls/Found on Floor' algorithm, directed staff to complete a 'Post Fall Huddle' after a resident falls, ensuring all fields be completed.

A resident experienced a fall that resulted in significant injury. The Post-Fall Huddle was left incomplete. An MoRC confirmed this was incomplete and that the expectation was for it to be completed.

Not completing a Post Fall Huddle posed a risk of mitigating future falls.

Sources: CIS report, the resident's clinical health record, the licensee's policies 'Post Fall Follow up, Assessment & Management' (#19-01-05, last revised August 2017) and addendum 'Falls/Found on Floor' algorithm (last revised September 2018), and interviews with staff.

B. The licensee's policy, 'Post Fall Follow up, Assessment & Management', directed staff to initiate a Head Injury Routine (HIR) for all unwitnessed falls.

A resident experienced a fall. A review of the clinical health record identified that the HIR was not fully completed. This was confirmed by an and MoRC. The MoRC confirmed that this should have been fully completed.

Not completing a HIR posed a risk of not identifying neurological injuries.

Sources: the resident's clinical health record, the licensee's policy 'Post Fall Follow up, Assessment & Management' (#19-01-05, last revised August 2017), and interviews with staff. [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 any plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring devices or techniques when assisting a resident.

The licensee's policy, 'Post Fall Follow up, Assessment & Management', directed staff to transfer residents off the floor post-fall using a total mechanical lift, unless the resident was able to get up without any assistance from staff.

A resident experienced a fall resulting in significant injury. According to a progress note written by an RN, the resident was manually assisted to a transfer chair by three staff post-fall. This was confirmed through interview with the RN.

In interviews with an MoRC and the SNM, it was confirmed that as per the home's zero lift policy, the resident should have been transferred off of the floor by a mechanical lift.

Manually lifting the resident off of the floor posed a risk of further injury to the resident.

Sources: CIS report, the resident's clinical health record, the licensee's policy 'Post Fall Follow up, Assessment & Management' (#19-01-05, last revised August 2017), and interviews with staff. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control (IPAC) program.

The home's policy 'COVID-19 Outbreak Protocols by Department/Role' directed staff to ensure that clean personal protective equipment (PPE) was to be stored appropriately in the respective storage, such as inside the over-the-door caddie or tower.

On three home areas, the following was observed:
i. One face shield was exposed and hanging on the outside of the door caddie on the door of a resident room;
ii. Two face shields were exposed and hanging on the outside of the door caddie on the door of a resident room; and,
iii. Three face shields were exposed and sitting on top of the PPE cart outside of a resident room.

The staff did not store the face shields as required. This was confirmed by the SNM.

Not properly storing the face shields posed a risk of contamination.

Sources: The home's internal protocol 'COVID-19 Outbreak Protocols by Department/Role', observations and interviews with the SNM. [s. 229. (4)]

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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #4: 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. (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. (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 has failed to ensure that staff collaborated with each other in the assessment, development and implementation of a resident's plan of care so that the different aspects were integrated and consistent with and complemented each other.

A resident's plan of care was reviewed, including the written care plan and most recent Resident Assessment Instrument Minimum Data Set (RAI-MDS). The written care plan and the MDS data did not match in multiple areas. In addition, while speaking with front line staff, further discrepancy was noted between the assessments, care plan and the present condition of the resident.

In an interview with an MoRC, they acknowledged that the assessments, care plan and present condition of the resident were not consistent with or complemented each other.

Having inconsistencies within the plan of care posed a risk of not meeting the resident's appropriate care needs.

Sources: the resident's clinical health record, observation of the resident and interviews with staff. [s. 6. (4)]

2. The licensee has failed to ensure that the care set out in a resident's plan of care was reviewed and revised when their care needs changed.

A resident's written care plan identified the resident's primary mode of locomotion as a wheelchair. Upon observation of the resident and interviews with multiple staff, it was confirmed that the resident used a walker as the primary mode of locomotion.

Sources: the resident's clinical health record and interviews with the PT, MoRC and other interdisciplinary staff. [s. 6. (10) (b)]

Issued on this 15th day of July, 2021

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

Original report signed by the inspector.