Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: July 29, 2024

Inspection Number: 2024-1618-0003

Inspection Type:
Complaint
Critical Incident

Licensee: The Regional Municipality of Halton

Long Term Care Home and City: Creek Way Village, Burlington

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 9-12, 15-18, 2024.

The following intake(s) were inspected:
- Intake: #00113130 was related to a resident hydration and infection prevention and management.
- Intake: #00116953 was related to a fall of a resident.
- Intake: #00118747 was related to an infection outbreak management.

The following **Inspection Protocols** were used during this inspection:

Food, Nutrition and Hydration
Infection Prevention and Control
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (2)
The licensee of a long-term care home failed to ensure that the care set out in the plan of care was based on an assessment of the resident and on the needs and preferences of that resident.

Rationale and Summary:
Revisions to a resident's care plan were made on a day in May 2024, reflected post fall interventions and associated care needs, including specified interventions.

A Physiotherapy Assessment completed on a day in May 2024, indicated staff were to continue to ensure the specified intervention used as per their falls risk and prevention strategy.

On a day in June 2024, the resident's care plan was revised to reflect changes to the specified intervention, deeming this intervention as resolved. The Registered Practical Nurse (RPN) confirmed they made the revisions to the care plan but were unable to recall why, provided a rationale or documentation to support the revisions. The Registered Nurse (RN) confirmed revisions were made to the resident's care plan, specifically related to the specified intervention, and that additional documentation to support the change was not found.

Throughout the time period between a day in June 2024 to a day in July 2024, the resident did not sustain any injuries or experienced further falls. Additional falls risk

and prevention interventions were in place as per the resident's care needs.

Failure to ensure care set out in the care plan was based on assessment could negatively impact the continuity of care and the resident's safety.

On a day in July 2024, the resident's care plan was revised by the RPN, to include the use of the specified intervention when the resident was in bed as an active falls risk and prevention intervention.

Sources: The resident's clinical files; interviews with the registered staff.

Date remedied: July 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 29 (3) 10.
The licensee of a long-term care home failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 10. Health conditions, including allergies, pain, risk of falls and other special needs.

Rationale and Summary:
A resident's progress notes documentation stated that the resident's Power of Attorney (POA) voiced a concern about pain in a specified resident's body site, which the resident confirmed to the POA.
Electronic Medication Administration Record in March and April 2024 indicated that the resident was on an analgesic medication for pain/comfort.

The resident's care plan did not contain focus, goal and intervention for pain management based on an interdisciplinary assessment of the resident.

The RN indicated that a pain management was to be included in the resident's care plan if they were on pain medications, which was confirmed by the Resident Care Manager.

Sources: Progress Notes, Care Plan, Medication Administration Record; interviews with the registered staff and the Resident Care Manager.

Date Remedy Implemented: July 2024

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
The licensee of a long-term care home failed to ensure to implement, (b) any standard or protocol issued by the Director with respect to infection prevention and control.

Rationale and Summary:
General Notes in Progress Notes documentation in Point Click Care (PCC) software dated in March 2024, stated a specified observation about a resident's body fluids. The resident's care plan directed staff to monitor and report any complaints of the following to the registered staff in relation to specified changes to the resident's body fluids.
The RN indicated that the infection was to be followed up and monitoring was to be documented in Progress Notes and/or in "Twenty Four Hours Resident Condition Report Evaluation" every shift by staff.

Progress notes for a specified period of time in March 2024, and "Twenty Four

Hours Resident Condition Report Evaluation" book did not identify symptoms records and immediate actions taken in relation to the General Note in PCC Progress Notes dated a day in March, 2024.

Sources: Care plan, progress notes, "Twenty Four Hours Resident Condition Report Evaluation"; interview with the registered staff.