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
Mar 6, 2020	2020_830752_0006	001169-20	Critical Incident System

Licensee/Titulaire de permis

Bay Haven Nursing Home Incorporated
499 Hume Street COLLINGWOOD ON L9Y 4H8

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

Bay Haven Nursing Home
499 Hume Street COLLINGWOOD ON L9Y 4H8

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

LUCIA KWOK (752)

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): February 25-28, and March 2, 2020.

The following intake was completed in this Critical Incident System Inspection: Log #001169-20 related to a fall resulting in an injury.

During the course of the inspection, the inspector(s) spoke with residents, the Assistant Administrator, Director of Nursing (DON), Clinical Nursing Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapist (PT), and Personal Support Workers (PSW).
The inspector conducted a tour of the home, observed the provision of care, and resident and staff interactions. The inspector reviewed pertinent clinical records, and relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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 the plan of care was reviewed and revised when the resident's care needs changed.

A Critical Incident was submitted to the Ministry of Long Term Care (MLTC) related to a fall resulting in an injury.

The home's policy titled, Falls Prevention and Management Program, last revised December 2018, directed registered staff to ensure the care plan and kardex were updated and to implement immediate changes to fall prevention strategies as required.

Personal Support Worker (PSW) #102 stated that staff referred to the kardex and/or care plan on Point Of Care (POC) for a resident's specific care needs.

A) Resident #001 fell on an identified date and sustained an injury.

Registered Nurse (RN) #104 and Registered Practical Nurse (RPN) #105 stated that resident #001 had a significant change in their condition after the fall. RPN #105 stated that as per the home's policy, the physiotherapist made the final recommendation on residents' transfer status.

Physiotherapist (PT) #106 assessed and recommended that resident #001 receive an identified level of assistance following their fall.

RPN #105 stated that they transferred resident #001 after the fall incident incorrectly. RPN #105 and Director of Nursing (DON) #101 acknowledged that the resident's care plan was not revised as per the physiotherapist's new recommendations.

B) Resident #002 fell on an identified date.

After the fall incident, resident #002's progress note indicated that they were to return to their previous transfer status. There was no evidence of new recommendations from the physiotherapist after the fall incident.

Resident #002's care plan stated that they required an identified level of care for transfers. RPN #103 stated that the signage in a resident's room was considered part of their plan of care.

On an identified date, the Long Term Care Homes (LTCH) inspector observed contradicting instructions on the transfer signage in resident #002's room. RPN #109 and PSW #110 said that the signage indicated the incorrect instructions for transfers and was not updated as required.

The licensee has failed to ensure that the residents #001 and #002's plan of care was reviewed and revised when their care needs changed. [s. 6. (10) (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 the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A Critical Incident was submitted to the MLTC related to a fall resulting in an injury.

The home's policy titled, Pain Management Program, last revised December 2018,

directed registered staff to screen for the presence of pain and/or complete an clinically appropriate assessment tool in Point Click Care (PCC) on admission, readmission, quarterly, with significant change, when a resident reports or exhibits signs and symptoms of pain, and/or following the implementation of pharmacological and non-pharmacological interventions. It directed registered staff to monitor and evaluate the effectiveness of pain medication in relieving the resident’s pain using the numerical or painad scale. DON #101 stated that if initial pain interventions were ineffective, registered staff were expected to contact the physician or nurse practitioner for further assessment and interventions.

A) Resident #001 sustained an unwitnessed fall on an identified date and sustained an injury.

After the fall incident, PT #106 stated that resident #001 was assessed as experiencing pain and had facial grimacing with movement.

Resident #001's progress notes documented that they continued to be in severe pain, pain medication was administered and non-pharmacological interventions were all ineffective. Following this, RN #104 notified the physician of ineffective pain management and requested a reassessment.

There was no evidence that the home's clinically appropriate tools for pain assessment were completed after resident #001 fell or when they complained of pain on identified dates.

B) Resident #002 sustained a fall on an identified date.

A progress note documented that resident #002 had pain in an identified area. On an identified date, resident #002 complained of on and off pain in an identified body part. Following this, the resident complained of severe pain in an identified area of their body.

There was no evidence that the home's clinically appropriate tools for pain assessment were completed after resident #002 fell and when they complained of pain on identified dates.

The licensee has failed to ensure that when residents #001 and #002's pain were not relieved by initial interventions, the residents were assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

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 when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

Issued on this 9th day of March, 2020

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

Original report signed by the inspector.