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
Sep 9, 2020	2020_792659_0017	005859-20	Critical Incident System

Licensee/Titulaire de permis

MacGowan Nursing Homes Ltd.
719 Josephine Street P.O. Box 1060 WINGHAM ON N0G 2W0

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

Braemar Retirement Centre
719 Josephine Street North, R.R. #1 P.O. Box 1060 WINGHAM ON N0G 2W0

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

JANETM EVANS (659)

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): August 19 and 20, 2020.

The following intake was included in this inspection:
Log #005859-20\Critical Incident (CI) #2773-000005-20 related to a resident fall with injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

Observations related to resident care and fall interventions made. Clinical records and relevant policies and procedures were reviewed.

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

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

Resident #001 was at risk for falls.

The care plan for resident #001 documented the resident should wear hip protectors at all times.

Progress note documentation for a four week period documented hip protectors were not available for the resident on 15/30 days or 50% of the time.

On three of five observations completed over a two day period, resident #001 was not wearing hip protectors.

RN #103 acknowledged resident #001 was not wearing hip protectors and they should have been wearing them.

The licensee failed to ensure that the plan of care for resident #001 had been followed related to to the resident wearing hip protectors at all times. [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 resident #001 wearing hip protectors at all times as per their plan of care, to be implemented voluntarily.

WN #2: 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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any strategy , the strategy was complied with.

In accordance with O. Reg. 79/10, the licensee was required to ensure that the home had a falls prevention and management program to reduce the incidence of falls and the risk of injury. The strategy was to include the monitoring of residents.

Specifically, staff did not comply with the licensee’s head injury routine (HIR) strategy dated November 8, 2019, which was part of the home's fall prevention and management program.

The home's HIR documented that all residents with a confirmed head injury or a high suspicion of head injury have a head injury routine completed at the time of the incident. The routine was to consist of full neuro vitals, range of motion (ROM) x 24 hours at a specified frequency, post head injury assessment, and nursing staff were to continue to monitor residents for six shifts with regular vitals, a pain assessment and late onset of symptoms.

(a) Risk Management documentation, stated resident #001 had an unwitnessed fall. They sustained an injury from this incident.

HIR documentation for this incident, showed four of 10 checks were not completed over the 24 hour period.

(b) Risk Management documentation, stated resident #003 had an unwitnessed fall.

HIR documentation for this incident, showed five of 10 checks were not fully completed over the 24 hour period.

The DOC said it was not acceptable to write 'sleeping' or leave blanks in the HIR documentation and this had been a problem in the past.

The licensee has failed to ensure that the strategy related to head injury routine was complied with for resident #001 and resident #003. [s. 8. (1) (a),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 all staff following the home's policy for completion and documentation of the head injury routine, to be implemented voluntarily.

Issued on this 10th day of September, 2020

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

Original report signed by the inspector.