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
Dec 16, 2020	2020_831211_0014	002315-20, 021996-20	Critical Incident System

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue Woodstock ON N4S 3V9

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

Caressant Care Bourget
2279 Laval Street P.O. Box 99 Bourget ON K0A 1E0

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

JOELLE TAILLEFER (211)

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): November 2, 3, 4, 5, 6, 9, 10, 16, 26, 2020

The following intakes Log #002315-20 and #021996-20 were inspected related to falls prevention and safe and secure home.

During the course of the inspection, the inspector(s) spoke with Regional Director, Administrator, Director of Nursing & Interim Director of Nursing (DON), Acting Director of Nursing (ADOC), Clinical Practice Lead, Physiotherapist, Occupational Therapist, Registered Nurse (RN), Registered Practical Nurses (RPNs), Fall Champion Personal Support Worker, Behavioural Supports Ontario PSW (BSO/PSW), Physiotherapist Assistant, and the Clerk.

In addition, the inspector reviewed the residents' health care records, the Post Fall Investigations, the Post Head Injury Assessment Form, the policies and procedures related to Head Injury Routine, Safety Plan-Resident, and Personal Assistive Service Devises (PASD).

The following Inspection Protocols were used during this inspection:
Falls Prevention
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 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 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 the care set out in the plan of care for a resident who exhibited responsive behaviors by repeatedly attempting to transfer or to stand-up from the bed or the wheelchair and consequently had multiple falls was provided as specified in the plan.

The licensee submitted a Critical Incident Report (CIS) that indicated a resident sustained an injury after a fall.

Review of the resident's progress notes indicated that since admission the resident had multiple falls. Several personal assistance services devices' interventions were put in place to reduce injuries or to prevent falls.

Review of the physician orders indicated that the resident needed one on one (1:1) care. The next day, the resident's progress notes indicated that the 1:1 was effective at times. Twenty-one days later, the physician orders indicated to discontinue the one on one.

During an interview, the Regional Director stated that they didn't have any records indicating that the resident was provided with a 1:1 staff nor that "High Intensity Needs Funds" (HINF) were requested. Thus, the care set out ordered by the physician to have a 1:1 staffing for the resident's care was not provided as specified in the resident's plan of care.

Sources: Residents #004's progress notes, Physician orders and interview with the Regional Director #121. [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 that the care set out in the plan of care is provided to the resident as specified in the plan, 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 Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

Specifically, the licensee did not comply with the licensee's policy "Head Injury Routine" Dept Nursing dated September 2019, that indicated the following:
• immediately after a resident sustains a trauma to the head or an unwitnessed fall, the Registered Staff in charge is to assess the resident, using the Post Head Injury Assessment Form and do a complete set of vital signs.
• Using the Post Head Injury Assessment Form as a documentation tool and vital signs, assess the resident for 72 hours with the following frequency:
-Every half hour for the first 2 hours following the injury
-Every hour for the next 24 hours
-Every 4 hours for the next 8 hours
-Every shift for the remainder of the 72-hour monitoring.
• The resident must be woken up to complete the vital signs and assessment if they are sleeping.

In an interview with the ADOC stated that the Registered Nursing staff should have written the reason why the neurological signs were not documented on the "Post Head Injury Assessment" form beside each time required to assess a resident after a fall as the above "Post Head Injury Form" instruction for the 72 hours. The ADOC could not clarify if the attempt to take the resident's neurological signs was made by the Registered Nursing Staff at the frequency indicated in the "Post Head Injury Assessment" form.

As such, the Registered Nursing staff didn't complete the "Post Head Injury Assessment Form" for fourteen dates as indicated in the above "Head Injury Routine" policy. [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 where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #004 had a fall, the resident was reassessed and that where the condition or circumstances of the resident, a post-fall assessment was conducted using a clinical appropriate assessment instrument that was specifically designed for falls.

Resident #004's progress notes and the post fall investigation forms indicated that a post-fall assessment was not conducted using a clinical appropriate assessment instrument that was specifically designed for falls for four days.

Sources: Residents #004's progress notes and post fall investigation forms. Interview with ADOC #102. [s. 49. (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 had a fall, the resident was reassessed and that where the condition or circumstances of the resident, a post-fall assessment was conducted using a clinical appropriate assessment instrument that was specifically designed for falls, to be implemented voluntarily.

Issued on this 4th day of January, 2021

[redacted]

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

Original report signed by the inspector.