Ontario

Ministry of Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère des Soins de longue durée

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 5, 2020	2020_520622_0007	001550-20	Critical Incident System

Licensee/Titulaire de permis

Carveth Nursing Home Limited
375 James Street GANANOQUE ON K7G 2Z1

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

Carveth Care Centre
375 James Street GANANOQUE ON K7G 2Z1

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

HEATH HEFFERNAN (622)

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): March 3, 4, 5, 2020.

Critical Incident log #001550-20/INFOLINE IL-73982-AH/Critical Incident System report (CIS) #2683-000002-20, related to an incident that caused injury to a resident for which the resident was taken to the hospital and that resulted in a significant change in the resident’s health status.

During the course of the inspection, the inspector(s) spoke with the President/Director, Director of Care (DOC), Assistant Director of Care (ADOC), a Registered Practical Nurse (RPN), Personal Support Workers (PSWs) and the resident.

Also, during the course of the inspection, the inspector reviewed the Critical Incident System report (CIS), the hard copy and electronic health records, the licensee's Falls Prevention and Management policy dated August 15, 2019, registered and non-registered staff schedules, and observed resident care and services.

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

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
1 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. 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 #002 fell, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

On March 3, 2020, inspector #622 reviewed resident #002's progress notes on Point Click Care which stated that on a specified date and time, resident #002 sustained a fall. Resident #002 sustained an injury and was transferred to the hospital which resulted in a significant change in their health status.

On March 4, 2020, inspector #622 reviewed the Assessment tab on Point Click Care for resident #002, which indicated that a GFHC Post Fall assessment Tool had been opened on a specified date and time. The GFHC Post Fall assessment Tool was noted to have two out of five sections completed, (the vital signs and the Power of Attorney notification). The GFHC Post Fall assessment Tool stated that all sections were to be completed.

On March 4, 2020, inspector #622 reviewed the Assessment tab on Point Click Care for resident #002, which indicated that a Falls Risk Assessment was opened on a specified date and had no areas completed within the document.

During an interview with inspector #622 on March 4, 2020, Director of Care (DOC) #100 stated that after all resident falls, a post fall assessment is to be completed using the GFHC Post Fall assessment Tool on Point Click Care which also triggers the Falls risk assessment, DOC #100 stated that it would be expected that both assessments would be completed. DOC #100 reviewed the GFHC Post Fall assessment Tool and the Falls Risk Assessment on Point Click Care which had been opened, but not completed for resident #002 on the specified date. DOC #100 stated that a post fall assessment had not been completed for the fall of resident #002 on the specified date. [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 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the outcome or current status of resident #002 who was involved in an incident under subsection O. Reg. 79/10, s. 107 (3.1) within 10 days of becoming aware of the incident.

Critical Incident System report (CIS) #2683-000002-20 which was submitted on a specified date, indicated that resident #002 was involved in an incident on a specified date two days earlier. Resident #002 suffered an injury and was transferred to the hospital, which resulted in a significant change in their health status. The CIS report stated that resident #002's outcome/current status was that they remained in the hospital and several attempts had been made by the long-term care home to contact the hospital for additional information, but no information had been received.

Inspector #622 reviewed the Ministry of Long-Term Care, critical incident system reporting website, and (CIS) #2683-000002-20 had not been amended to indicate what resident #002's outcome/current status was after their return to the long-term care home from the hospital.

On March 3, 2020, inspector #622 reviewed resident #002's progress notes on Point Click Care which indicated that six days after the incident occurred, resident #002 returned to the long-term care home from the hospital with a significant change in their health status.

During an interview with inspector #622 on March 4, 2020, Director of Care #100 stated that they had not amended CIS #2683-000002-20 to include the outcome/current status of resident #002 upon their return from the hospital on six days after the incident occurred. [s. 107. (4) 3. v.]

Issued on this 22nd day of May, 2020

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

Original report signed by the inspector.