Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 17, 2016	2016_284545_0020	016933-16, 021541-16, 015162-16	Critical Incident System

Licensee/Titulaire de permis

CITY OF OTTAWA
Long Term Care Branch 275 Perrier Avenue OTTAWA ON K1L 5C6

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

CENTRE D'ACCUEIL CHAMPLAIN
275 PERRIER STREET VANIER ON K1L 5C6

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

ANGELE ALBERT-RITCHIE (545)

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): July 20, 21, 22, 25 and 26, 2016

Three Critical Incidents related to falls were inspected:
- Log #: 016933-16 and Log #: 015162-16 regarding a fall with an injury with a transfer to hospital and change in status
- Log #: 021541-16 regarding improper/incompetent treatment of a resident during a transfer

Three Complaint Inspections were also inspected during this Critical Incident Inspection:
-Log # 016924-16
-Log # 019943-16
-Log # 020814-16

Note that you will find non-compliance related to the Complaint Inspections issued in this Critical Incident Inspection (WN #001), as well as in the Complaint Inspection report #2016_284545_0021.

During the course of the inspection, the inspector(s) spoke with the Program Manager of Resident Care/Acting Administrator, Program Manager of Personal Care, RAI Coordinator, Rehab Assistant, Physiotherapy Assistant, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Workers (PSW), and residents.

The inspector also conducted a tour of the resident care areas, reviewed residents' health care records, home's policies and procedures related to Falls Prevention and Safe Transfer Techniques, staff work routines and schedules, observed resident rooms, observed resident common areas, and observed the delivery of resident care and services, including resident-staff interactions.

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

During the course of this inspection, Non-Compliances were issued.

5 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	Legendé 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

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 has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care, such as assistance with transfers, to resident #002.

Resident #002 was admitted to the home with several medical conditions. According to the resident's health record it was documented that the resident was at high risks of falls as frequently transferred self without requesting assistance from staff. Resident #002 fell on a specified date in May 2016 which resulted in an injury, and was hospitalized. The resident fell again on a specified date in July 2016 and suffered an additional injury and was sent to the Emergency Department.

Upon request of the current written plan of care for resident #002, RPN #124 provided the inspector with three documents:
-Assignment Sheet available in a binder at the nurse's station which is reviewed daily at the beginning of each shift, indicated that the resident required a total mechanical lift for

all transfers (last revised: September 2015)
-Kardex available with the Assignment Sheet, indicated that the resident was independent with non-supervised transfers or assistance of one person (last revised: March 2016)
-Care Plan available in a binder in the chart room, indicated that the resident was at risk of falls with additional risk factors, and interventions included strategies on how to manage falls.

In a review of a Critical Incident Report (CIR) submitted by the home one day post-fall in July 2016, it was documented that resident #002 had a fall during a transfer by mechanical lift the previous day which resulted in an admission to hospital with an injury.

PSW #122 indicated that she had access to the care plan. After reading the Kardex which she took from the binder at the nurse's station, she indicated that the plan of care did not provide clear direction to staff as it was stating that the resident was independent with transfers, however the resident had been requiring a full mechanical lift since the resident's return from a hospitalization several weeks ago.

RPN #124 indicated that the plan of care did not provide clear direction to staff related to type and level of assistance resident #002 required with all transfers, including resident's resistance to care.
(Log #: 021541-16) [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to resident #005, such as repositioning while in wheelchair and daily use of front closure seatbelt.

Resident #005 was admitted to the home with several medical condition including severe cognitive impairment.

[A] Related to repositioning:
During observations on July 21, 22, 25 and 26, 2016, the resident was observed in a tilt wheelchair with a front closure seatbelt and a table top. The resident's arms were observed resting on small cushions placed on the table top, and during observations the resident was noted to move his/her arms and hands towards his/her face or neck and mild twitching of one leg was also observed.

In a review of the most current written plan of care, it was documented:

- under the section Repositioning and turning (printed care plan), to change resident #005's position every hour when sitting in the tilt wheelchair;
- under the section Activities of Daily Living (printed care plan), it was indicated to check the resident's positioning every one to one and a half hour when in the wheelchair; and
- in the printed Kardex, it was documented to change the resident's position using the tilt every one to two hours when up in the wheelchair.

Instructions to staff in the written plan of care regarding repositioning of resident #005 while in the tilt wheelchair, varied between 1 hour, 1.5 hour and 2 hours.

PSW #106 indicated that the resident was brought to his/her bedroom after each meal at the family's request and placed in front of his/her television and that the resident was repositioned in the tilt wheelchair, as required. She added that the resident needed to be positioned as per the pictures posted on the walls but was unsure how frequent the repositioning needed to be done.

RPN #130 indicated that PSWs were responsible to reposition the resident, as required when up in the tilt wheelchair, using the pictures posted on the wall as guidelines.

During an interview with the Program Manager/Acting Administrator, she indicated that the repositioning plan of care would be updated to provide clear direction to staff.

[B] Related to use of front closure seatbelt:
According to the most recent RAI-MDS assessment, it was documented that restraints by physical device for resident #005 was not in use.

During observations on July 21, 22, 25 and 26, 2016, the resident was observed in a tilt wheelchair with a front closure seatbelt and a table top. The resident's arms were observed resting on small cushions placed on the table top, and during observations the resident was noted to move his/her arms and hands towards his/her face or neck and mild twitching of one leg was also observed. The resident was unable to physically or cognitively unfasten the seatbelt.

Pictures of the resident in the tilt wheelchair were observed posted on the walls in the resident's bedroom. On one of the pictures, in step 3, it was documented to "adjust my seatbelt (not too tight)".

In a review of the care plan, Kardex and daily flow sheets, information related to the use

of a front closure seatbelt was not found.

RN #109 indicated that the seatbelt was used as a personal assistance service device (PASD) for positioning while resident #005 was reclined in the wheelchair. She added that the seatbelt had been requested by the resident’s family, and that it was required as the resident tended to slide forward. The RN further indicated that it had been her intention to update the written plan of care to provide clear direction to staff related to the daily use of the front closure seatbelt when resident #005 was in a tilt wheelchair.

The written plan of care did not provide clear direction to staff related to the use of front closure seatbelt. (Log #: 019943-16) [s. 6. (1) (c)]

3. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to resident #004, such as daily application of hearing aids.

During an interview with resident #004 on July 21, 2016 at lunch time, the resident asked the Inspector to speak louder as he/she could not hear. When asked where his/her hearings aids were, the resident indicated he/she didn't know. On July 22, 2016 at breakfast in the dining room, the Inspector observed resident #004, with no hearing aids in place.

According to the most recent RAI-MDS assessment, resident #004 had adequate hearing with use of hearing aids. It was also noted that the resident didn't use the hearing aids regularly.

PSW #107 and #108 indicated that resident #004 did not have any hearing aids.

In a review of the resident's written plan of care, updated March 2016, it was documented that resident #004 required daily application of hearing aids.

During an interview with RN #109, she indicated that resident #004's hearing aids were kept locked in the Medication Cart in case the family requested application when visiting. She further indicated that they had not been used for a long time, added that the resident didn't keep them on. The RN indicated that it was the home's practice to document daily application of hearing aids in the Medication Administration Record (MAR), however it didn't appear in this resident's MAR. She added that the resident's hearing needs would need to be reassessed in discussion with the resident's family, and then based on

resident/family's preference, the plan of care would be updated with the goal to provide clear direction to staff and others who provide direct care to resident #004. (Log #016924 -16) [s. 6. (1) (c)]

4. The licensee has failed to ensure that care set out in the plan of care such as application of glasses was provided to resident #004 as specified in the plan.

Inspector #545 observed resident #004 on July 21, 2016 at 1245 hours, on July 22, 2016 at 0815 in the dining room, and again at 1030 hours watching television in an opened space near the nursing station. On all three occasions, resident #004 did not have his/her glasses on.

According to the most recent RAI-MDS assessment (June 2016), resident #004 wore glasses for impaired vision.

In a review of the resident's written plan of care, updated March 2016, it was documented that resident #004 had impaired vision and staff were expected to ensure that glasses were cleaned and applied daily.

PSW #106 and RPN #105 indicated that resident #004 often removed the glasses, therefore they were not applied. They both indicated that the glasses were kept locked in the Medication Cart.

RN #109 indicated that staff were expected to keep resident #004's glasses at the bedside and apply them daily, at the request of the resident's family. (Log #016924-16) [s. 6. (7)]

5. The licensee has failed to ensure that when resident #001 was reassessed, that the plan of care was reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

In a review of a Critical Incident Report (CIR) submitted by the home, it was documented that resident #001 had a fall on a specified date in May 2016, and the resident was sent to hospital with an injury.

Resident #001 was admitted to the home with several medical conditions including dementia and vascular disease. According to the health record, resident #001 was transferred to palliative care on a specified date in June 2016 with a deterioration of the

resident's general condition, frequent falls and dementia.

On July 25, 2016, Inspector #545 observed resident #001 in the dining room sitting in a slightly reclined Broda chair with no seat belt. The resident was calm and very sleepy.

In a review of the progress notes, it was documented that resident #001 had 10 falls between May and July 2016 due to the resident's inability to follow instructions, and forgetting to use his/her walker. On a specified date in July 2016 it was documented that the resident was found on the floor in front of the Broda chair. The note indicated that the resident was now spending all of his/her time in the Broda chair.

In a review of the written plan of care, it was documented in the current Kardex that the resident was presently in a tilt wheelchair with a front closure seatbelt, and that when the resident was anxious, the resident was at higher risk for falls. In the current written care plan, staff were instructed to ensure a safe environment when the resident walked, and to ensure the walker was nearby. In another intervention, it was documented that the resident no longer walked and required a two-person transfer.

During an interview with RN #110, she indicated that the resident was changed from a tilt wheelchair to a Broda chair on a specified date in July 2016 but the printed Kardex and care plan available to direct care staff had not been updated to reflect this change. She further indicated that the care plan should have also been updated to include risk of falls, and the instruction regarding the front closure seatbelt should have been removed, as the restraint had been discontinued. (Log# 016933-16) [s. 6. (10) (b)]

6. The licensee has failed to ensure that resident #003's plan of care was revised when the resident's care needs changed related to safety risk following three falls within a two-day interval.

Resident #003 was admitted to the home with several medical conditions. In an assessment completed on a specified date in April 2016 it was documented that resident #003 required limited assistance of one person for transfers, moved between locations in the home using a wheelchair, and had no history of falls or fractures in the past six months.

According to the resident's health record, it was documented that the resident was found on the floor on three occasions in April and May 2016. After the first fall, it was documented in the progress notes that a full mechanical lift was required for transfers as

the resident's lower body was too weak to support his/her weight. The resident was admitted to the hospital on a specified date in May 2016 and diagnosed with specified lung condition and a fracture of a specified region.

A Risk Assessment Form Tool (RAFT) was completed after the third fall indicating that the resident was at high risk for falls (score of 16).

In a review of the written plan of care, there was no documentation to indicate that the resident was at high risk for falls.

RN #125 indicated during an interview that the resident' #003's written plan of care had not been revised to include safety risks related to the three falls. (Log #: 015162-16) [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 plans of care provide clear directions to staff and others who provide direct care, such as:
-assistance with transfers for resident #002
-repositioning while in tilt wheelchair and use of front closure seatbelt for resident #005
-application of hearing aids for resident #004

to ensure that resident #004 is provided with care as set out in the plan such as daily application of glasses

to ensure that resident #001's plan of care is reviewed and revised to include safety risk related to falls, 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 failed to ensure that the home's policy "Falls Prevention Program" was complied with.

As per O.Reg 79/10, s. 48 (1) 2, every licensee of a long-term care home shall ensure that the following interdisciplinary programs is developed and implemented in the home: a falls prevention and management program to reduce the incidence of falls and the risk of injury, and s. 48 (2) whereby each program must, in addition to meeting the requirements set out in section 30, (a) provide for screening protocols; and (b) provide for assessment and reassessment instruments.

A review of the home's Falls Prevention Program, March 2016, including the Falls Prevention Program: Resident Assessment for Falls Tool (RAFT), AP & OP No: 315.08, September 2013 was done and it was documented that the registered staff will:

Item 2: Host a post fall meeting (Huddle) and complete the Huddle form on the shift when the fall occurred. In the event of an unwitnessed fall, head injury will be assessed and neuro vital signs will be taken.

Item 3: Complete the Resident Assessment for Falls Tool (RAFT) when the condition or circumstances of the resident require:
• Upon admission
• Where there is an injury from falling requiring hospitalization
• If the resident has more than 2 falls in a 1 week (7 days) period

During an interview with Program Manager #101, she indicated that the "Formulaire d'évaluation post-chute pour résident/facteurs de l'environement" (Huddle form) was the

home's paper format of the post-fall assessment tool and that the registered staff were expected to complete one each time a resident had a fall, witnessed or unwitnessed. She further indicated that registered staff were expected to photocopy the completed Huddle Form and send the copy to her for tracking. She indicated that this initiative allowed her to follow-up on falls and ensured the policy was followed.

Related to Log: #016933-16, for resident #001

Resident #001 was admitted to the home with several medical conditions including dementia and vascular disease. According to the resident's health record, the resident was at high risk for falls as was unable to follow instructions.

In a review of resident #001's progress notes from May to July 2016, it was documented that the resident had 10 falls. A post-fall assessment (Huddle Form) was not found for three out of 10 falls:

• a specified date in May 2016: resident was found on floor in front of the bathroom door, with a head injury, 911 was called and the resident was sent to the Emergency Department;

• eight days later: resident found sitting on floor in the resident's bedroom, slid off the bed while trying to get to the bathroom. No apparent injuries, was transferred to the wheelchair by two staff; and

• three weeks later at 0442 hours: fell on the floor during transfer, staff were unable to keep the resident up due to weight. No apparent injuries, was lifted off the floor and transferred to bed by full mechanical lift.

Program Manager #002 was unable to find completed post-fall assessments for the above three falls. [s. 8. (1) (a),s. 8. (1) (b)]

2. Related to Log #: 021541-16, for resident #002

Resident #002 was admitted to the home with several medical conditions. According to the resident's health record it was documented that the resident was at high risk of falls as frequently transferred self without requesting assistance from staff.

In a review of the resident's progress notes, it was documented that the resident had a

fall on a specified date in May 2016. A post-fall assessment (Huddle Form) was not found: resident was found on the floor as coming out of the bathroom, hitting his/her head. A skin tear was observed on a specified limb and the resident described pain as 10 out of 10 to a specified region.

The resident was transferred to hospital via ambulance and was admitted. According to the notes, the resident returned to the home on four days later with a fracture to a specified region requiring a full mechanical lift for all transfers. A Resident Assessment for Falls Tool (RAFT) was not found, as per the home's Fall Policy.

RPN #124 and Program Manager #002 were unable to find a completed post-fall assessment and a RAFT for this fall. [s. 8. (1) (a),s. 8. (1) (b)]

3. Related to Log #: 015162-16, for resident #003

Resident #003 was admitted to the home with several medical conditions. According to the resident's health record, there was no documentation to indicate that this resident was at risk of falls.

In a review of the resident's progress notes, in a note dated on a specified date in April 2016, it was documented that the resident was found on the floor at 0850 hours. The resident was trying to self-transfer from the toilet to the wheelchair when his/her legs could no longer support the resident's weight and he/she collapsed to the floor. The resident was lifted off the floor with the assistance of four staff with the use of a full mechanical lift. Other than scratches on the resident's back, no other injuries were noted.

A post-fall assessment (Huddle Form) was not found.

RN #125 indicated that registered staff were expected to complete a post-fall assessment (Huddle Form) each time a resident had a fall. She was unable to find one for a fall dated on a specified date in April 2016 when resident #003 fell. [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 comply with the home's Falls Prevention Program, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used a safe transferring and positioning device or technique when assisting resident #002 with a transfer.

Resident #002 was admitted to the home with several medical conditions. According to the resident's health record it was documented that the resident was at high risk of falls as frequently transferred self without requesting assistance from staff.

In a review of the Critical Incident Report (CIR) it was documented that resident #002 fell during a transfer on a specified date in July 2016, whereby a sit-to-stand mechanical lift was used. According to the CIR, the resident had been assessed for a full mechanical lift since return from hospital on a specified date in May 2016, following a fall with an injury to a specified region.

Program Manager #101 provided the Inspector with the home's Lifting & Transferring Program, P&P No: 350.05, revised February 2016. Under the section Practice, it was documented that "Two staff members must be present when a mechanical lift, including the tub chair is used. One staff member operates the mechanical lift while the second member guides and protects the resident as well as explains the procedure".

In a review of the resident's health record, it was noted that the resident was at "very high risk" for falls due to an injury to a specified region, and weakness due to flu-like symptoms for four specified days in July 2016, and again starting six days later.

According to a Falls Resident Assessment Protocol (RAP) completed on a specified date in June 2016, it was documented that the resident required a full mechanical lift for transfers, however was frequently observed self-transferring.

In a progress note dated a specified date in July 2016 at 1413 hours, it was documented that the resident had stayed in bed all day, with no complaints. At 2306 hours, a registered staff documented that the resident was feeling less weak after eating supper, and at 2220 hours, a staff member informed the registered staff that resident #002 had fallen while staff were transferring the resident using a sit-to-stand mechanical lift. The resident suffered a head injury with heavy bleeding. At 2322 hours, it was noted that the resident was sent to the Emergency Department.

During an interview with PSW #123, she indicated that she assisted PSW #131 with transferring resident #002 on the evening of a specified date in July 2016. She indicated that the resident was often weak and was unable to stand on his/her own. She added that the resident did not like staff to use the full mechanical lift; therefore that evening, they decided to use the sit-to-stand mechanical lift. PSW #123 indicated that while she was busy moving objects in the resident's bedroom to make space for the lift, PSW #131 applied the sling behind resident #002 and then started to lift the resident. PSW #123 indicated that once the resident was fully lifted, the resident let go of the handles and fell to the floor, hitting his/her head on the floor or the side of the chair. PSW #123 further indicated that she should have been behind the resident, to guide and protect the resident.

Program Manager #101 indicated that staff were expected to use a safe transfer technique, as per the home's policy for residents/staff safety. (Log #: 021541-16) [s. 36.]

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 staff use safe transferring and positioning device and/or technique when assisting residents with transfer, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #002, at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, upon any return of the resident from hospital.

Resident #002 was admitted to the home with several medical conditions including cerebral vascular disease.

In a review of resident's health record, it was documented that resident #002 had a fall on a specified date in May 2016 that resulted in an injury of specified region which required hospitalization. Four days later, it was noted that the resident returned to the home.

According to a RAI-MDS assessment completed on a specified date in May 2016, it was documented that the resident scored four out of eight on the interRAI Pressure Ulcer Risk Scale, indicating a higher relative risk of developing a pressure ulcer.

During an interview with RPN #124, she indicated that registered staff were expected to complete a skin assessment using the home's "Outil d'évaluation de la peau", #355.29A, revised April 2011, however upon return from hospital on a specified date in May 2016, one was not completed for resident #002. (Log #: 021541-16) [s. 50. (2) (a) (ii)]

WN #5: 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. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee failed to contact the hospital within three calendar days, and did not inform the Director of the incident within three business days after the occurrence of the incident to ensure that where an incident occurred that caused an injury to resident #003 for which the resident was taken to a hospital.

The home submitted a Critical Incident Report (CIR) to the Director under the LTCHA on a specified date in May 2016 for an incident that occurred 12 days earlier.

In a review of resident #003's progress notes in April 29 and May 2016, it was documented that the resident had fallen three times while self-transferring to the bathroom. With the third fall the resident was found with decreased muscular strength in both lower and upper limbs, numbness and pain to one knee, as well as a head injury. Notes indicated that the resident refused to go to hospital, and that the resident was provided new medication for a pulmonary condition. Three days following the third fall, the resident complained of feeling "paralysed" and asked to go to the hospital. Resident #003 was admitted to the hospital on that same day and returned to the home 15 days later with a diagnosis of an injury to a specified region and a pulmonary condition. There was no documentation to indicate the home had contacted the hospital within three calendar days, and no documentation to indicate that the home had informed the Director under the LTCHA of the incident within three business days after the occurrence of the incident.

During an interview with Program Manager/Acting Administrator, she indicated that staff were expected to call the hospital to follow-up on resident's status post hospitalization. She indicated that recently staff reported that the hospital staff refused to provide a medical update indicating they were unable to share information with anyone other than the person who had power of attorney. She further indicated that if this was the case, the registered staff or herself would document this refusal in the resident's progress notes. The Program Manager/Acting Administrator was unable to find evidence of documentation demonstrating the home had contacted the hospital within three calendar days to determine whether the injury to resident#003 had resulted in a significant change in the resident's health condition. She further indicated that she could not explain why the home did not inform the Director under the LTCHA of the incident within three business days after the occurrence of the incident; the home informed the Director five business days after the resident was sent to hospital. (Log #: 015162-16) [s. 107. (3.1)]

Ontario

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

Rapport d’inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 19th day of August, 2016

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

Original report signed by the inspector.