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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

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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
Feb 19, 2020	2020_773155_0003	021470-19, 023132-19	Critical Incident System

Licensee/Titulaire de permis

Collingwood Nursing Home Limited
250 Campbell Street COLLINGWOOD ON L9Y 4J9

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

Collingwood Nursing Home
250 Campbell Street COLLINGWOOD ON L9Y 4J9

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

SHARON PERRY (155), SARAH INGLIS (767)

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 3, 4, 5, and 6, 2020.

During this inspection log # 021470-19 and log # 023132-19 were completed related to incidents that caused injury for which the resident was taken to hospital and there was a significant change in the resident's health status.

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

The inspectors also toured resident care areas; reviewed relevant clinical records; and observed staff to resident interactions and falls prevention equipment.

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

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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that when resident #002 was being reassessed and the plan of care was being revised because the care set out in the plan was not effective, that different approaches were considered in the revision of the plan of care.

Review of resident #002's clinical record showed they had fallen multiple times.

On identified dates, resident #002's care plan fall interventions were updated to include specific interventions.

Resident #002 continued to fall despite having the specific interventions in their care plan.

Review of resident #002's progress notes showed that staff had concerns with the specific interventions as they were ineffective in preventing resident #002 from falling.

Resident #002 fell on an identified date and caused injury for which the resident was taken to hospital and there was a significant change in the resident's health status.

Registered Nurse #109 shared that resident #002 was often seen removing specific equipment. Assistant Director of Care (ADOC) #105 and Director of Care (DOC) #101 also shared that resident #002 was often seen with the equipment in their hands. ADOC #105 and DOC #101 shared that they were aware that resident #002 was able to remove equipment.

When DOC #101 and ADOC #105 were asked if different interventions were tried when resident #002 consistently removed the equipment, they said no.

The licensee failed to ensure that when resident #002 was being reassessed and the plan of care was being revised because the care set out in the plan was not effective, different approaches were not considered in the revision of the plan of care. [s. 6. (11) (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 when the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

a) Record review showed that resident #003 had fallen on a number of occasions. On an identified date, resident #003's care plan stated that resident #003 was at risk for falls and was to be checked every hour to ensure their safety.

Review of the Falls Incident/Fall Huddle Report for resident #003's falls on two identified dates, did not include that resident #003 was on increased monitoring for safety at the time of these falls.

Review of Point of Care Documentation Survey report for the identified period of time did not include any documentation that resident #003 was checked hourly.

Director of Care #101 shared that they were not able to see documentation in Point of

Care to indicate that resident #003 was checked every hour. They also acknowledged that the Falls Incident/Fall Huddle Report for resident #003's falls did not include that resident #003 had increased monitoring for safety interventions in place at the time of these incidents.

b) On an identified date, the home submitted a Critical Incident Report stating that resident #001 had a fall that caused injury for which the resident was taken to hospital and there was a significant change in the resident's health status.

Record review for resident #001 showed that they had multiple falls during an identified period of time. On an identified date, resident #001's care plan was updated and stated that resident #001 was to be checked every half hour for safety.

Review of the Falls Incident/Fall Huddle Report for resident #001's fall on an identified date, did not include that resident #001 was on increased monitoring for safety at the time of the fall.

Review of Point of Care Documentation Survey report for the identified time period, did not include any documentation that resident #001 was checked every half hour.

Director of Care #101 shared that they were not able to see documentation in Point of Care to indicate that resident #001 was checked every half hour. They also acknowledged that the Falls Incident/Fall Huddle Report for resident #001's fall did not include that the resident had increased monitoring for safety interventions in place.

c) On an identified date, the home submitted a Critical Incident Report stating that resident #002 had a fall that caused injury for which the resident was taken to hospital and there was a significant change in the resident's health status.

Record review for resident #002 showed that they had multiple falls during an identified period of time. On an identified date, resident #002's care plan was updated and stated that resident #002 was to be checked every half hour for safety.

Review of the Falls Incident/Fall Huddle Report for resident #002's falls on identified dates, did not include that resident #002 was on increased monitoring for safety at the time of the falls.

Review of Point of Care Documentation Survey reports for the identified period of time,

did not include any documentation that resident #002 was checked every half hour for safety.

Director of Care #101 shared that they were not able to see documentation in Point of Care to indicate that resident #002 was checked every half hour or hourly. They also acknowledged that the Falls Incident/Fall Huddle Report for resident #002 on the identified dates, did not include that the resident had increased monitoring for safety interventions in place.

The licensee failed to ensure that actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, 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 failed to ensure that when resident #002 fell on an identified date, that a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Registered Practical Nurse (RPN) #104 and #107 shared that when a resident falls they complete a Fall Incident/Fall Huddle Report in Point Click Care.

Review of resident #002's point click care assessments showed that there was no Fall Incident/Fall Huddle Report completed for resident #002 after they fell on an identified date.

Assistant Director of Care #105 and Director of Care #101 acknowledged that the Fall Incident/Fall Huddle Report was not done for resident #002 after they fell on the identified date.

The licensee failed to ensure that when resident #002 fell on an identified date, that a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls. [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.

Issued on this 2nd day of March, 2020

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

Original report signed by the inspector.