Ontario

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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 6, 2019	2019_595110_0010	019642-19	Critical Incident System

Licensee/Titulaire de permis

Estonian Relief Committee in Canada
40 Old Kingston Road SCARBOROUGH ON M1E 3J5

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

Ehatare Nursing Home
40 Old Kingston Road SCARBOROUGH ON M1E 3J5

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

DIANE BROWN (110)

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 1(PM) and 4, 2019.

Critical Incident Report (CI) related to falls management.

During the course of the inspection the inspector conducted observations of the home area and resident #001, record reviews and reviewed relevant policies and procedures.

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

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 failed to ensure the care set out in the plan of care provided to the resident as specified in the plan.

The Ministry of Long Term Care received a Critical Incident (CI) report from the home, documenting that resident #001 had a fall which resulted in a significant change of status.

A record review of progress notes identified that on an identified date resident #001 required close observation and an intervention was initiated. During the time of close observation the resident had a fall. A record review of the resident's written plan of care in place at the time of the fall identified a falls prevention intervention.

An interview with PSW #102 and RN #103 identified that the identified intervention had not been in place at the time of the resident's fall.

An interview with the DOC confirmed that resident #001's care, related to the use of an identified intervention as set out in their plan of care, was not provided to the resident as specified in their plan. [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 the care set out in the plan of care 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. 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 the resident has fallen, the resident has been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The Ministry of Long Term Care received a Critical Incident (CI) report from the home, documenting that resident #001 had a fall which resulted in a significant change of status.

A record review of a progress note, entered by RN #103, documented that on an identified date and time PSW #102 found that resident #001 had fallen.

A review of resident #001's written plan of care, in place at the time of the CI, revealed fall prevention interventions.

A record review of the resident’s health record, post fall, identified a 72 hours nursing assessment of resident #001's clinical status; a falls risk assessment tool (FRAT), post fall huddle along with a quality management report.

A review of the records failed to review if the resident's fall prevention interventions were in place at the time of the resident's fall or were potential and contributing factors. The forms in use did not evaluate the resident’s patterns of fall episodes, daily patterns or prior routines or medication use and effect or potential adverse drug reactions and impact.

An interview with RN #103 stated that were unsure of what would be considered the home’s post fall clinically appropriate assessment instrument that is specifically designed for falls and referred to the 72 hr clinical assessment of the resident as the home's post fall instrument.

An interview with the Falls Prevention Lead in the home RN #104 shared they were unsure of the home’s post fall clinically appropriate assessment instrument that is specifically designed for falls and stated the nurses complete a 72 hour nursing assessment of the resident's health condition.

An interview with the DOC shared that they thought the FRAT tool was the suitable post fall assessment tool, but recognized it only assessed the resident’s risk of fall and was

not evidence of a clinically appropriate assessment instrument that was specifically designed for falls and did not investigate the resident's fall. [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 the resident has fallen, the resident has been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

Issued on this 22nd day of November, 2019

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

Original report signed by the inspector.