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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 19, 2019	2019_790730_0037	023187-19	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the County of Elgin Municipal Homes
450 Sunset Drive 3rd Floor, Suite 303 ST. THOMAS ON N5R 5V1

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

Elgin Manor
39262 Fingal Line, R.R. #1 ST. THOMAS ON N5P 3S5

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

CHRISTINA LEGOUFFE (730)

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): December 10, 11, and 12, 2019.

The following Critical Incident System (CIS) intake was included in this inspection:

Log #023187-19/ CI #M518-000046-19 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Resident Care (MRC), a Resident Care Coordinator (RCC), a Registered Dietitian (RD), Registered Nurses (RNs), a Registered Practical Nurse (RPN), Personal Support Workers (PSWs), and resident(s).

The inspector also reviewed resident clinical records and plans of care, polices and procedures of the home, and observed residents and the care provided to them.

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

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 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 :

The licensee has failed to ensure that where the Act or the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any strategy, the licensee was required to ensure that the strategy was complied with.

In accordance with O. Reg. 79/10, s. 48 (1) 1, and in reference to O. Reg. 79/10, s. 49 (1) the licensee was required to have a falls prevention and management program that provided strategies to monitor residents.

Specifically, staff did not comply with the licensee's "Post Fall Assessment and Management Algorithm," which was part of the licensee's Falls Prevention and Management program, which required registered staff to complete a Head Injury Routine (HIR) after a resident had fall resulting in a suspected head injury or an unwitnessed fall.

The home's policy titled "Falls Prevention and Management" stated under the heading definition "An un-witnessed fall occurs when a resident is found on the floor and neither the resident nor anyone else knows how he or she got there." Under the heading "Fall and Post Fall Assessment and Management" the policy stated in part that "Registered staff will: 3. Initiate head injury routine for all unwitnessed falls and witnessed falls that have resulted in a possible head injury or if the resident is on anticoagulant therapy. (Use neurological flow sheet)."

A) The Ministry of Long-Term Care (MOLTC) received a Critical Incident Systems (CIS) report on a specified date, which was related to an incident which resulted in a significant change in resident #001's health status. The CIS report stated that the resident had experienced multiple falls within a 24-hour period, with one of the falls occurring while the resident was away from the home.

A review of resident #001's medical diagnoses in Point Click Care (PCC), showed a diagnosis which indicated cognitive impairment, upon admission to the home.

A review of the progress notes in PCC, for resident #001, for a specified range of dates, showed several notes indicating that the resident had sustained a specified number of falls, many of which were unwitnessed. One of falls was noted to have occurred offsite and another was documented to have resulted in a head injury to the resident. The resident was noted to have required additional assistance with transfers.

Review of a diagnostic imaging report in resident #001's paper chart, stated that the resident had a specified injury.

Review of resident #001's paper chart by inspector #730 showed a document titled "Elgin Manor Neurological Record," with a specified date. This document included one assessment at a specified time. No other Neurological Records for the indicated time period were found in resident #001's paper chart.

During two separate interviews between resident #001 and inspector #730, when asked if the resident had a fall recently, the resident said no.

During an interview, Registered Nurse (RN) #103 said that head injury routines (HIRs) were completed when a resident had an unwitnessed fall, or if the fall was witnessed and the resident hit their head. RN #103 said that they would probably not take a resident's word for it that they did not hit their head during a fall, if they were cognitively impaired. They said that they documented HIRs on a paper form titled "Neurological Record" and that a new HIR would be started after each new fall, based on that fall. RN #103 said that they were familiar with resident #001. They said that there should have been HIRs completed for resident #001 related to specified falls on named dates. They said that the only HIR they could find was related to the fall on a specified date when the resident hit their head, but that it did not appear to have been initiated immediately after the fall.

During an interview, Manager of Resident Care (MRC) #101, said that they were still in the process of getting answers related to resident #001's change in health status and that they were unsure if the specified injury came before or was a result of one of resident #001's falls.

During a second interview, MRC #101 said that related to resident #001's fall when they

hit their head, registered staff did not follow the home's policy related to HIR. They said that the HIR had been initiated but not completed as per the home's policy, as it was documented that the resident hit their head. They said that the expectation was that the "Neurological Record" would be completed every 30 minutes for two hours, every hour for the next four hours, every four hours for the next eight hours, and every eight hours for the next 72 hours. They also said that they would expect that a new HIR would be initiated for every new fall which required an HIR. [s. 8. (1) (a),s. 8. (1) (b)]

2. Resident #003 was identified, during an interview, by Resident Care Coordinator (RCC) #106, as a resident who had recently sustained an unwitnessed fall.

A review of the progress notes in PCC for resident #003, showed a note on a specified date titled "Fall-Initial Assessment," which stated that a PSW alerted the writer that resident #003 had an unwitnessed fall, with no visible injuries.

Review of resident #003's paper chart by inspector #730, did not show any Neurological Records from the date of resident's unwitnessed fall.

During an interview with Registered Practical Nurse (RPN) #109, they said that they were familiar with resident #003. They said that resident #003 had an unwitnessed fall. They said that they did not see a HIR completed related to that fall.

During an interview with MRC #101, they said that they would expect that a HIR would have been completed related to resident #003's fall on a specified date, but that they did not think that one had been completed.

The licensee has failed to ensure that the home's strategy for Falls Prevention and Management was complied with, related to the completion of head injury routines, when residents #001 and #003 fell.

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 home's policy related to the completion of head injury routines is complied with, 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 a post- fall assessment was conducted, using a clinically appropriate assessment when a resident fell.

The Ministry of Long-Term Care (MOLTC) received a Critical Incident Systems (CIS) report on a specified date, which was related to an incident which resulted in a significant change in resident #001's health status. The CIS report stated that the resident had experienced multiple falls within a 24-hour period, with one of the falls occurring while the resident was away from the home.

A review of the progress notes in Point Click Care (PCC), for resident #001, showed that the resident had sustained a fall while away from the home, as well as another unwitnessed fall out of bed.

Review of the assessments section in PCC, for resident #001, did not show post-falls assessments completed related to resident #001's falls on a specified date, outside of the home, or a subsequent fall at the home. No post falls "Risk Management" entry was found for the offsite fall. The "Risk Management" entry for resident #001's fall at the

home on the subsequent date, displayed under the triggered user-defined assessments (UDAs) section that the “Post Fall Screen for Resident/Environmental Factor” was “In Progress,” that the “Pain Assessment” was “Not Created” and the “Head to Toe Assessment” was “Not Created.”

During an interview, Registered Nurse (RN) #103, said that registered staff were responsible for initiating a falls risk management entry which included three assessments: a pain assessment, a head to toe assessment, and a falls risk strategies and environmental factors assessment. They said that the assessments needed to be completed within 24 hours after the fall. RN #103 said that if a resident fell while outside of the home they would expect that the same assessments would have been completed upon their return to the home, as if the fall had occurred in the home. RN #103 said that no risk management was initiated, and no post falls assessments were documented related to resident #001’s fall outside of the home, however, they expected that they would have been completed. Related to resident #001’s fall on the subsequent date, RN #103 said that a post- falls assessment had not yet been completed related to this fall.

During an interview, Manager of Resident Care (MRC) #101, said that it did not meet the home’s expectation when the post-falls assessment related to resident #001’s fall, which occurred on a specified date was not completed until two days later. They said that they expected that registered staff would have completed the post-falls assessment during the shift when the resident fell. MRC #101 also said that registered staff should have completed a post- falls assessment related to the resident’s fall outside of the home, but had not.

The licensee has failed to ensure that a post-falls assessment was completed when resident #001 fell.

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 falls a post-falls assessment is completed, to be implemented voluntarily.

Issued on this 23rd day of December, 2019

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

Original report signed by the inspector.