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

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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
Jan 8, 2020	2019_803748_0013	013963-19, 013964-19, 013965-19, 013967-19, 016431-19, 018238-19	Critical Incident System

Licensee/Titulaire de permis

City of Hamilton
28 James Street North 4th Floor HAMILTON ON L8R 2K1

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

Macassa Lodge
701 Upper Sherman Avenue HAMILTON ON L8V 3M7

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

EMMY HARTMANN (748)

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 11, 12, 16, 17, 18, and 19, 2019.

The following intakes were completed in this Complaint Inspection:

Log #018238-19, was related to a fall that resulted in a transfer to hospital.
Log #016431-19, was related to a fall that resulted in a transfer to hospital.
Log #013967-19, was related to a follow-up inspection to compliance order #001, regarding LTCHA s. 6. (10), with the compliance due date of November 16, 2019.
Log #013963-19, was related to a follow-up inspection to compliance order #002, regarding Ontario Regulation s. 8. (1), with the compliance due date of November 16, 2019.
Log #013965-19, was related to a follow-up inspection to compliance order #003, regarding LTCHA s. 29. (1), with the compliance due date of November 16, 2019.
Log #013964-19, was related to a follow-up inspection to compliance order #005, regarding Ontario Regulation s. 49. (2), with the compliance due date of November 16, 2019.

During the course of the inspection, the inspector(s) spoke with residents, the Senior Administrator, Director of Nursing, Nurse Managers, Recreationist, Business Office Lodge Clerk, Staffing Clerk, Administrative Assistant, registered nurses (RN), registered practical nurses (RPN), and personal support workers (PSW).

During the course of the inspection, the inspector also observed the provision of care and services, and reviewed records, and policies.

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

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)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 29. (1)	CO #003	2019_725522_0007	748
O.Reg 79/10 s. 49. (2)	CO #005	2019_725522_0007	748
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2019_725522_0007	748
O.Reg 79/10 s. 8. (1)	CO #002	2019_725522_0007	748

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 that the care set out in the plan of care was provided to the resident as specified in the plan.

Log #016431-19, CI M552-000038-19, was related to a fall of resident #002, for which the resident was transferred to the hospital and resulted in a significant change in condition of the resident.

A review of assessments completed for resident #002, identified that there was a Falls Risk Assessment completed on an identified date, which indicated the resident at risk for falls.

A review of resident #002's plan of care for falls identified that the resident had interventions implemented on an identified date, by RN #105.

Progress Notes documented on an identified date and time in August 2019, by RN #105, identified that resident #002 was found on the floor, and that the resident was known for self-transferring. It also identified that specific interventions would be applied and that the resident's family member was notified and was agreeable with the plan.

Interview with RN #105, confirmed that the specific interventions were not implemented for the resident until a specified date, and that they were not in place when the resident fell on an identified date in August 2019, as per the resident's plan of care.

During an interview with Nurse Manager #104, they acknowledged that resident #002's plan of care for falls was not provided to the resident, as specified in the 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 that the care set out in the plan of care is 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. 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 has failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with s. 49 (1) O. Reg 79/10, the home was to have a Falls Prevention and Management program that must at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

Specifically, staff did not comply with the licensee's policy "Fall Management Program NM 03-02-08", last reviewed September 14, 2018, which stated "the interdisciplinary team to conduct the fall risk assessment when a change in health puts them at risk for falling such as a significant change in health status, falls resulting in serious injury, and in response to frequent falls, to determine if change in risk level exists".

Log #018238-19, Critical Incident #M552-000041-19, was related to a fall of resident #001, for which the resident was transferred to the hospital and which resulted in a significant change in condition of the resident.

A review of resident #001's progress notes identified that they have several un-witnessed falls in September of 2019, was transferred to hospital and had a change in condition.

A review of the assessments completed for resident #001, identified that a Falls Risk Assessment was conducted on the resident on an identified date, which indicated they were at risk for falls. There was no Falls risk Assessment conducted on the resident

after they fell four times in September of 2019. The next Falls Risk Assessment conducted on the resident was when they returned from hospital, to which they had change in risk for falls. The assessment indicated that interventions were initiated for the resident.

Interview with Nurse Manager #104, identified that resident #001 had frequent falls as per the home's policy. They acknowledged that there should have been a Falls Risk Assessment completed when the resident was falling frequently, where interventions could have been implemented to prevent more falls, such as those put in place after the resident had returned from the hospital.

The home failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

Issued on this 24th day of January, 2020

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

Original report signed by the inspector.