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
Feb 17, 2017	2016_298557_0012	024926-16	Critical Incident System

Licensee/Titulaire de permis

HUNTSVILLE LONG TERM CARE CENTRE INC.
689 YONGE STREET MIDLAND ON L4R 2E1

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

MUSKOKA LANDING
65 ROGERS COVE DRIVE HUNTSVILLE ON P1H 2L9

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

VALERIE PIMENTEL (557)

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): October 5, 6 and 11, 2016.

The following critical incident was inspected: Log #024926-16

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Unit Coordinator, Restorative Care Coordinator, Environmental Service Manager, Physiotherapist, Registered Nurse(s) (RN), Registered Practical Nurse(s) (RPN), Personal Support Worker(s) (PSW) and Housekeeping Aide(s) (HKA)

During the course of the inspection, the inspector conducted observations of the residents and home areas, staff and resident interactions, provision of care, reviewed clinical records, minutes of fall prevention committee meetings, work orders for equipment repair and relevant policy and procedures.

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

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)**

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Review of a Critical Incident (CI), dated in July 2016, revealed that an identified resident had a fall in an identified hallway that resulted in transfer to hospital for assessment. The resident was diagnosed with a fractured.

In an identified month in 2016, at an identified time, the identified resident was found lying on the floor. The resident was assessed by the registered staff using the home's post fall/post fall assessment tool. He/she displayed no symptoms of a fracture at the time of the incident, other than there was an observed redenned area. The resident ambulated with with two staff member to the nursing station and was placed in a chair for observations and later taken to bed. Through the night, the resident was observed rubbing an identified area on his/her body, the resident was heard moaning loudly. The following day the resident was sent to the hospital and diagnosed with a fracture. The resident returned the same day, the directions from the emergency physician was to encourage to stay in bed as much as possible.

A review of the plan of care for the identified resident, identified the following:
The written care plan identified the following interventions for each category identified:
Mobility - requires assistance by identified staff members to provide supervision, cueing and one staff for safety when ambulating in hallways, walking to dining room and on or off the home area.
Bed mobility - independent
Transfers - identified staff members were to provide supervision to ensure safety, the resident may require minimal physical assistance.
Falls - ensure environment is clutter free, call bell clipped within reach, to have adaptive equipment on when dressed for day, to wear specialized foot wear.
Mood - identified to allow resident to wander unit with proper foot wear and that some activities of daily living may trigger identified behaviors.

The kardex identified the following:
Resident is able to transfer with assistance and can weight bear.
Requires two person assistance for all transfers and staff to use adaptive equipment whenever necessary.

Interview with an identified staff member, identified the resident was ambulatory and was to wear specialized foot wear prior to his/her fall and further confirmed after his/her fall the resident's activities of daily living changed and he/she had declined. Review of the written care plan and kardex with the identified staff member confirmed the directions for care provision for the identified resident were not correct after his/her fall in an identified month in 2016.

Interview with a second identified staff member, he/she identified the resident health had declined, as the identified resident was not comfortable and required total care with all activities of daily living. The identified staff member further indicated the resident had been prone to falls and interventions had been implemented but changed. Review of the written care plan and kardex with the identified staff member confirmed the directions for care provision for the identified resident were not correct after his/her fall.

Interview with an identified registered staff member confirmed the resident had progressive decline in his/her overall mental and physical well being since admission. The registered staff member confirmed the resident did not recover to his/her previous lifestyle after the fall. Review of the written care plan with the identified registered staff member confirmed the written care plan and kardex did not give clear direction to the staff who provide direct care to the identified resident.

Interview with a second identified registered staff member described the resident as having advanced cognitive issues and was not able to convey his/her needs of activities of daily living and displayed some identified behaviors prior to the fall. After the fall the identified registered staff member confirmed the identified resident health continued to decline and that his/her previous activities of daily living were no longer applicable and that the resident now require complete care. The written care plan and kardex were reviewed and confirmed as not being accurate to identify the resident's decline in health status. He/She further confirmed the written care plan was not updated and did not provide clear direction to the staff.

Interview with the unit coordinator and the DOC confirmed the written plan of care for the identified resident did not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: 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) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Review of a critical incident (CI) report, dated in an identified day and month in 2016, identified a specific resident had an injury and was sent to hospital which resulted in a significant change in status confirming a fracture. The report was not submitted until three business days after the occurrence of the incident.

An interview with the DOC confirmed the report was not submitted to the Director within one business day. [s. 107. (3) 4.]

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Issued on this 17th day of February, 2017

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

Original report signed by the inspector.