Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

# Inspection Report under the Long-Term Care Homes Act, 2007

# Rapport d'inspection prévue 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 Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Dec 9, 2019 | 2019_746692_0034 | 017766-19, 022420-19, 022548-19 | Critical Incident System |

## Licensee/Titulaire de permis

The District of the Municipality of Muskoka
98 Pine Street BRACEBRIDGE ON P1L 1N5

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

The Pines
98 Pine Street BRACEBRIDGE ON P1L 1N5

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

SHANNON RUSSELL (692)

## 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 26-29, 2019.**

**-One log, which was related to a critical incident that the home submitted to the Director regarding a fall of a resident, which resulted in a significant change in the resident's status; and,**
**-Two logs, which were related to critical incidents that the home submitted to the Director regarding abuse to residents, resulting in harm.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (DOC), Behavioural Support Ontario (BSO) lead, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.**

**The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident and resident to resident interactions, reviewed relevant health care records, internal investigation notes, as well as licensee policies, procedures and programs.**

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

**During the course of this inspection, Non-Compliances were issued.**
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 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 a resident has fallen, the resident was assessed using a clinically appropriate post fall assessment tool.

A Critical Incident System (CIS) report was submitted to the Director on an identified date, for an incident that caused injury to a resident, which resulted in a significant status change. A review of the CIS report identified that resident #001 had sustained two falls in the previous month and had been transferred to the hospital, resulting in a significant change in status.

The Inspector reviewed resident #001's health care records, identifying a progress note, dated on an identified date, that indicated that the resident had sustained a fall on that date. The Inspector conducted a further review of the health care records, and was unable to locate a completed post fall assessment, using the clinically appropriate post fall assessment tool from the home.

A review of the home's policy titled, "Fall Prevention and Management Program", #RC-15 -01-01, last updated August 2019, indicated that after a resident had fallen, registered staff were to hold a post-fall huddle, ideally within the hour, and complete a post-fall assessment, that was located in the assessment section in Point Click Care (PCC).

The Inspector interviewed Personal Support Worker (PSW) #102, who indicated that they were on duty on the identified date, and that they recalled resident #001 sustaining a fall during their shift.

In separate interviews with Registered Practical Nurse (RPN) #103 and Registered Nurse (RN) #105, they indicated to the Inspector that after a resident had sustained a fall, the registered staff were to complete a post falls huddle with the staff present, inputting the collected information in the post fall assessment in PCC. Together, the Inspector, along with the RPN and RN reviewed resident #001's health care records in PCC, and were unable to locate a completed post fall assessment. Both RPN #103 and RN #105 indicated to the Inspector that the post fall assessment had not been completed for the fall resident #001 had sustained on the identified date, and that it should have been.

In an interview with the Acting Director of Care (DOC), they indicated to the Inspector that after a resident had sustained a fall, it was the home's expectation that the resident

was assessed using the post fall assessment located in PCC. Together, the Acting DOC and the Inspector reviewed resident #001's health care records, which the post fall assessment could not be located. The Acting DOC indicated that the post fall assessment had not been completed for the fall that resident #001 had sustained on the identified date, however, it should have been. [s. 49. (2)]

2. The Inspector reviewed resident #002's health care records, identifying a progress note, dated on an identified date, documented by RN #106, that indicated that the resident had sustained a fall. The Inspector conducted a further review of the health care records, and located a post fall assessment that had been opened on the day resident #002 had fallen, however there was not any information documented in the assessment.

In an interview with RPN #104, they indicated that the registered staff were to complete a post fall assessment for all falls that the residents had sustained. RPN #104 identified that the purpose of the post fall assessment was to identify what had occurred to precipitate the fall, if the resident acquired any injuries, and what new interventions that could be implemented. The RPN reviewed resident #002's health care records and was unable to locate a completed post fall assessment for the fall they had sustained on the identified date.

The Inspector interviewed RN #106, who indicated to the Inspector that after a resident had sustained a fall, the registered staff were to complete a post falls huddle with the staff present, inputting the collected information in the post fall assessment in PCC. Together, the Inspector, along with the RN reviewed resident #002's health care records in PCC, and were unable to locate a completed post fall assessment. RN #106 indicated that they had recalled the fall that resident #002 had sustained on the identified date, and that they had initiated a post fall assessment, however they were unable to explain why they did not complete the assessment.

In an interview with the Acting DOC, they indicated to the Inspector that after a resident had sustained a fall, it was the home's expectation that the resident was assessed using the post fall assessment located in PCC. Together, the Acting DOC and the Inspector reviewed resident #002's health care records, which a completed post fall assessment could not be located. The Acting DOC indicated that the post fall assessment had not been completed for the fall that resident #002 had sustained on the identified date, and it should have been. [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 using a clinically appropriate post fall assessment tool, to be implemented voluntarily.***

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**Issued on this 10th day of December, 2019**

[redacted]

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

**Original report signed by the inspector.**