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
Dec 7, 2020	2020_798738_0033	020622-20	Critical Incident System

Licensee/Titulaire de permis

Shanti Enterprises Limited
600 White's Road Palmerston ON N0G 2P0

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

Royal Terrace
600 Whites Road Palmerston ON N0G 2P0

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

AMANDA OWEN (738)

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 2 and 3, 2020.

The following Critical Incident System (CIS) intake was completed during this inspection:
- Log #020622-20, related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Assistant Administrator, Registered Nurses, a Registered Practical Nurse, Personal Support Workers and a resident.

The inspector(s) also toured the home, observed resident care provision and completed record reviews.

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

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 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 the home's Head Injury Routine (HIR) procedure, dated April 17, 2020, was complied with for three residents.

O. Reg. 79/10, s. 30, states that a written description of each interdisciplinary program required under section 48 of this Regulation, including falls prevention and management, is required and must provide methods to reduce risk and monitor outcomes of residents.

The home's HIR procedure, dated April 17, 2020, stated staff were required to check a resident's vital signs, pupil reaction and level of consciousness every 15 minutes for one hour, then every 30 minutes for two hours, then every hour for five hours, then every four hours for eight hours and then every eight hours for seven shifts. It said this information was to be documented on the HIR Record.

HIRs were implemented for three residents after they sustained unwitnessed falls on different dates and times. The HIR's were not completed as per the home's policy.

There was minimal risk of harm to one of the residents as they were identified to have a decreased level of consciousness and this could have been missed due to the home not completing the HIR as required. There was no harm or risk of harm to the other residents.

Sources: Post Fall Investigation, Royal Terrace LTC Head Injury Routine Record, progress notes and staff interviews.

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 staff comply with the home's HIR procedure,, to be implemented voluntarily.

Issued on this 10th day of December, 2020

[redacted]

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

Original report signed by the inspector.