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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 29, 2017	2017_591623_0016	006715-17, 009269-17, 010242-17	Critical Incident System

Licensee/Titulaire de permis

Glen Hill Terrace Christian Homes Inc.
200 Glen Hill Drive South WHITBY ON L1N 9W2

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

Glen Hill Strathaven
264 King Street East Bowmanville ON L1C 1P9

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

SARAH GILLIS (623)

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): August 15, 16, 17, 18, 21, 22 and 23, 2017

The following logs were inspected:
Log# 006715-17 - related to a missing/unaccounted for controlled substance.
Log# 009269-17 - related to a fall with an injury requiring transfer to hospital resulting in a significant change in resident's health status.
Log# 010242-17 - related to an allegation of improper care to resident by staff.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Nurse Educator, Nurse Practitioner (NP), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), resident's and family members

In addition, the inspector toured the home, observed staff to resident and resident to resident interactions, reviewed clinical health records, staff education records, program evaluations, the licensees internal investigation reports, Professional Advisory Committee (PAC) meeting minutes, policies related to falls prevention and management, abuse and neglect, critical incident reporting, narcotic count, and medication incident reporting.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation

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	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 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is:

(b) complied with related to O. Reg 79/10, s.48(1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury, which includes policies as indicated in O.Reg 79/10, s.30(1)1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

A review of the licensees policy: VI-G-60.00 Fall Prevention Management (current revision date January 2017)

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The initial post fall assessment note must include the following physical assessment for injuries:
1. Level of consciousness/evidence of seizure activity;
2. Evidence of gross injury i.e. bleeding, bone fragment protrusion, lacerations, hematomas;
3. Vital signs - TPR and BP (Capillary glucose monitoring and O2 sat may be applicable for assessment)
4. Assessment of damage to the hip joint - ie extreme pain, shortened and/or abduction of externally rotated leg, inability to weight bear;

5. Limited range of motion of joints; avoid moving against resistance, STOP if movement of a joint causes discomfort; palpate for tenderness of major joints and the rib cage.
6. Signs and symptoms of shock, hemorrhage;
7. Pain level identified i.e. guarding, facial expressions, grimacing and tension.

Post Falls Assessment
The Registered Staff will:

1. Assess the environment, before mobilizing, for clues as to objects which may have struck the resident during the fall or caused the fall;
2. If there is suspicion or evidence of injury the resident should not be moved. The physician should be contacted, and/or arrange for immediate transfer to hospital, the POA/SDM will be notified.
3. Mobilize the resident, ensuring that the appropriate lifting procedure is performed, if no injury evident, observe for pain or difficulty weight bearing.
4. Initiate a head injury routine if a head injury is suspected or if the resident fall is un-witnessed and he/she is on anticoagulant therapy.
5. Monitor head injury routine (HIR) for 48 hours post fall for signs of neurological changes, i.e facial droop, behavioural changes, weakness on one side etc.
6. Complete a thorough investigation of the fall incident including all contributing factors.
7. Complete Falls Incident Report under Risk Management portal in the computerized record; an associated progress note will be generated.
8. If a resident is transferred to hospital related to this fall, notify charge RN/ADOC/DOC to initiate the MOHLTC Critical Incident Reporting System. (CIS)
9. Re-evaluate the resident's care plan, make the appropriate interdisciplinary referrals, and document appropriate interventions to be taken.

Related to log#009269-17;

A Critical Incident Report (CIR) was submitted to the Director for an incident that occurred which caused injury to a resident for which the resident was taken to the hospital and which resulted in a significant change in the resident's health status.

Review of the CIR indicated that on a specific date and time, resident #005 was discovered on the floor. Resident #005 indicated to staff that they were getting up out of the chair and lost their balance and fell. On assessment RPN #120 noted an injury. Resident #005 was assessed and noted to be experiencing pain on movement. Nurse Practitioner (NP)#105 was called to assess resident #005 and ordered for resident to be

sent to the hospital for further assessment. The actual time of transfer to the hospital was not able to be verified as there was no documentation to indicate the transfer occurred.

Review of the clinical records for resident #005 including the progress notes for a specific time period indicated that there was no documentation on record to indicate that the fall had occurred. The first noted documentation was when the resident returned from hospital on the next shift.

Head injury routine (HIR) was initiated on a specific date and time by RPN #121.

On a specific date and time documentation was completed by RPN #120 in Point Click Care (PCC) under Risk Management Report for an incident that occurred four days earlier. This Risk Management Report, then generated a Post fall Assessment Note which provided details of the incident that occurred on a specific date and time, when resident #005 was found on the floor by staff, resulting in injury.

On August 22, 2017, at 1410 hours during an interview with Inspector #623, RPN #120 indicated that he/she was not working on a specified date, when resident #005 was discovered on the floor, and required transfer to the hospital. The RPN indicated that if he/she had been working then they would have completed a report in Risk Management to identify the fall which would have included an assessment, and a progress note would have been completed with the details of the fall. RPN #120 indicated he/she would have notified the substitute decision maker (SDM) of the fall, and if the resident was injured and required a transfer to the hospital then this would have also been documented. RPN #120 indicated that if the resident had an un-witnessed fall he/she would have also initiated a head injury routine sheet.

August 22, 2017, at 1420 hours during an interview with Inspector #623, the ADOC confirmed that RPN #120 was working the day shift on a specified date, in the home area where resident #005 resides.

August 22, 2017, at 1430 hours during an interview with Inspector #623, the Administrator indicated that the Risk Management report in PCC for resident #005's fall on a specific date was completed by RPN #120 as a late entry four days after the fall. The Post Fall Assessment note in PCC for the fall on a specific date, was also documented four days later by RPN #120 which described the fall and transfer to hospital. The Administrator confirmed that on the date the incident occurred, there was

no documentation by the day shift RPN #120, regarding resident #005's fall, assessment and transfer to hospital. There was a progress note written on that date by the evening RPN #121, which indicates that resident #005 returned from hospital at a specified time with a diagnosis of a specific injury. The first entry for the head injury routine for resident #005 is written on a specific date and time by RPN #121, which was was 1 hour and 25 minutes after the documented return from the hospital of resident #005. The Administrator indicated that it is the expectation of the licensee that the registered staff will complete the required documentation in PCC at the time a resident experiences a fall as outlined in the Fall Prevention & Management Policy.

August 23, 2017, at 1145 hours during an interview with Inspector #623, the DOC indicated that when a resident falls, the expectation is that documentation will be completed on the day that the incident occurs, by the RPN Charge Nurse on duty. This documentation should include a Risk Management Report for the fall, and a progress note Post Falls Assessment, both completed in Point Click Care, and the HIR initiated if indicated. The DOC indicated that at the time of resident #005's fall on a specific date, the RPN on duty was RPN #120. RPN #120 failed to document in Risk Management and in a Post Falls Assessment progress note, indicating the details of the fall including the assessment of the resident, the transfer to hospital and the notification of the SDM. The DOC also indicated that there was no record of a HIR being initiated by RPN #120 at the time of the un-witnessed fall, despite resident #005 sustaining an injury. The omission of documentation was discovered by the DOC four days after the fall occurred, at which time RPN #120 was instructed to complete the documentation that was required. [s. 8. (1) (a),s. 8. (1) (b)]

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 by ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

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Issued on this 30th day of August, 2017

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

Original report signed by the inspector.