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
Nov 26, 2019	2019_730593_0034	017829-19, 019682-19	Critical Incident System

Licensee/Titulaire de permis

Township of Osgoode Care Centre
7650 Snake Island Road METCALFE ON K0A 2P0

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

Township of Osgoode Care Centre
7650 Snake Island Road METCALFE ON K0A 2P0

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

GILLIAN CHAMBERLIN (593)

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 13 - 14, 2019.

Critical Incident (CIS) log numbers #019682-19 (2747-000006-19) and #017829-19 (2747-000005-19) were inspected related to incident's that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident’s health status.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nursing staff, Personal Support Workers (PSWs) and residents.

The Inspector observed the provision of care and services to residents, staff to resident interactions, resident to resident interactions, residents' environment, and reviewed resident health care records.

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 :

1. The licensee has failed to ensure that where the Act or this 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 r. 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.

Specifically, staff did not comply with the licensee’s “Falls Prevention and Management Program”, policy #VI-G-10.58, revision date April 2018, which is part of the home’s falls prevention and management program.

A Critical Incident report (CIS) was submitted to the Director, related to a critical incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident’s health status. It was reported in the CIS that resident #001 sustained an unwitnessed fall which resulted in a significant injury requiring surgery.

A review of the home’s policy “Falls Prevention and Management Program”, policy #VI-G-10.58, revision date April 2018, found the following:
Post Falls Assessment- the Registered Staff will:

4. If the resident has risen on their own initiative, post fall. Assist resident to the nearest chair and proceed with the head to toe assessment.

5. Mobilize the resident, ensuring that the appropriate lifting procedure is performed, if no injury evident, observe for pain or difficulty weight bearing.

6. The initial post-fall assessment must include the following physical assessment for injuries:
a. Level of consciousness/evidence of seizure activity
b. evidence of gross injury
c. Vital signs- TPR and BP
d. Assessment of damage to the hip joint
e. Limited range of motion of joints; avoid moving against resistance, STOP if movement of a joint causes discomfort; palpate for tenderness on major joints and the rib cage
f. Signs and symptoms of shock, hemorrhage
g. Pain level identified ie. guarding, facial expressions, grimacing, tension

7. Initiate a Head Injury Routine if:
a. a head injury is suspected
b. if the resident fall is unwitnessed and resident is incompetent

During an interview with Inspector #593, November 13, 2019, RPN #100 indicated that resident #001's fall happened right at supper time, adding that they did not do a very thorough assessment as the resident has had a lot of falls in their history and thought it was just like any other fall. RPN #100 indicated that they completed the risk management which included a post fall assessment, however did not complete a thorough head to toe because of timing. RPN #100 wanted to get the resident to the dining room for supper and it was close to the end of their shift. RPN #100 indicated that the resident did not receive a thorough head to toe until the following day, when they had another fall.

The progress notes were reviewed for resident #001. The progress notes indicated the following:

• Day 10, 2019- fall occurs approximately 1700 hours. Later that evening, resident ambulates to the nursing station to request analgesia. Nurse notes that resident was walking more slowly as if guarding their body.

• Day 11, 2019- resident complains of specific pain at lunchtime. Resident fell to their knees after leaving the dining room whilst heading back to their room. Nurse assessed specific area, no red marks, bruising or swelling. Resident was able to walk on their own, although slower than usual.

• Day 11, 2019- resident anxious and complaining of pain in the afternoon. Pointing to specific area, nurse assessed resident, no bruising, edema noted to area or external rotation or shortening noted.

• Day 11, 2019- resident sliding from chair at supper. Resident complaining of pain. Resident given Tylenol for specific pain with no effect. Resident resting with complaints of pain when standing up. Care completed in bed. Physician called who said they would assess the resident the following morning. SDM called and they felt that the resident should be assessed in hospital. 911 called and the resident sent to hospital.

• Day 12, 2019- SDM informed home that resident sustained a significant injury requiring surgery.

The risk management assessment completed by RPN #100 was reviewed by Inspector #593. The assessment completed did not document any assessment of lifting procedure, damage to the specific area, range of motion of joints and pain level.

During an interview with Inspector #593, November 14, 2019, RN #102 indicated that after resident #001's fall, a proper assessment should have been done including a head to toe and if RPN #100 was unable to complete this, there would have been another RPN and an RN in the building at that time who could have completed the assessment.

Resident #003 sustained a fall at 2135 hours. As per the progress note, the fall was unwitnessed. The residents head was assessed and there were no lumps or redness noted however staff were unsure if the resident hit their head. Approximately three hours after the fall, the resident was sent to hospital for assessment related to other health issues.

Resident #003's chart was reviewed by Inspector #593, there was no documentation related to commencement of the head injury routine before the resident was sent to hospital.

During an interview with Inspector #593, November 15, 2019, RN #102 indicated that after resident #003's fall, the head injury routine should have been initiated as the fall was unwitnessed and the resident was not competent to indicate whether they had hit their head or not.

After a fall occurring day 10, 2019, resident #001 was not assessed as per the policy. After a fall occurring day 9, 2019, the head injury routine was not initiated for resident #003 as per the policy. As such, the licensee has failed to ensure that the required policy Falls Prevention and Management Program was complied with. [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 ensuring that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy is complied with., to be implemented voluntarily.

Issued on this 26th day of November, 2019

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

Original report signed by the inspector.