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 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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 11, 2019	2019_788721_0020	000902-18, 008630-18, 017479-18, 000061-19	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

BayWoods Place
330 Main Street East HAMILTON ON L8N 3T9

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

MEAGAN MCGREGOR (721), AMBERLY COWPERTHWAITE (435)

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): June 4, 5, 6 and 7, 2019

The following Critical Incident (CI) reports were inspected during the course of this inspection related to falls prevention and management:

CI #2581-000044-18/Log #000061-19 ;
CI #2581-000013-18/Log #017479-18;
CI #2581-000001-18/Log #000902-18; and
CI #2581-000009-18/Log #008630-18.

During the course of the inspection, the inspector(s) spoke with the Executive Director (Acting), the Director of Care, two Associate Directors of Care, three Registered Practical Nurses and two Personal Support Workers.

The inspector(s) also observed residents and the care provided to them, reviewed clinical records and plans of care for identified residents and reviewed documentation related to the home's Falls Prevention and Management program.

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition, no later than one business day after the occurrence of the incident.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) related to a fall by resident #003 resulting in transfer to hospital on a specific date, which was five days prior to the date that the CIS report was submitted. The CIS report stated that on a specific date, which was four days after they fell, they were identified to have sustained a fracture.

A review of resident #003's progress notes in PointClickCare (PCC) showed that on a specific date and time staff found resident #003 on the floor in a sitting position after an unwitnessed fall and they were complaining of severe pain. Another progress note dated the same day as the fall, stated that resident #003 continued to complain of severe pain to their leg and the physician ordered an increase in resident #003's Tylenol and Dilaudid for "severe pain".

A review of resident #003's Assessments tab in PCC included the following documentation:
- A pain assessment dated the same day as the fall, indicating the reason for the assessment was "Change in Condition".
- A post fall assessment dated the same day as the fall, indicating the reason for the assessment was "significant change in condition".

Resident #003's progress notes in PCC included documentation from the date of the fall, stating that resident #003 had consented to being transferred to the hospital. Another progress note dated two days later, stated that upon resident #003's return from hospital on the previous day, there were no identified fractures. A progress note dated two days after the fall, stated that resident #003 was very apprehensive to move their leg and screamed when palpated. The progress note further stated that resident #003 was non-weight bearing on their leg. The progress note continued to state that the writer reviewed the x-ray reports and it was noted that resident #003 had a sustained fractures to their leg and was not to be transferred out of bed until confirmation of fractures. A progress note dated two days after the fall, stated that the physician ordered a splint for resident #003's leg. A progress note dated four days after the fall, stated that resident #003 was

identified to have sustained a fracture and that typographical errors were made.

During an interview with Associate Director of Care (ADOC) #103, when asked when resident #003 first had a change in their condition, ADOC #103 stated that resident #003 had a change in condition immediately after they fell on a specific date, when they were unable to walk with their walker. When asked if resident #003 had sustained a change in their condition after this fall, ADOC #103 stated yes. When asked when the MOHLTC was first notified of this incident, ADOC #103 stated that the MOHLTC was first notified when the resident had been confirmed to have sustained a fracture. ADOC #103 continued to state that resident #003 had sustained a significant change in status when the resident had the splint applied.

The licensee failed to ensure that the Director was informed within one business day, after resident #003 had a fall on a specific date, which resulted in a significant change in their status and transfer to hospital. The incident was first reported to the MOHLTC on a specific date, five days later. [s. 107. (3) 4.]

Issued on this 11th day of June, 2019

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

Original report signed by the inspector.