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

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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
May 2, 2019	2019_782736_0009	008213-19	Critical Incident System

Licensee/Titulaire de permis

Victoria Village Inc.
76 Ross Street BARRIE ON L4N 1G3

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

Victoria Village Manor
78 Ross Street BARRIE ON L4N 1G3

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

AMANDA BELANGER (736), TRACY MUCHMAKER (690)

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): April 23-26, 2019.

The following intake was inspected during the course of this Critical Incident inspection:
-One log related to a fall with significant injury and change in health status.

Complaint inspection #2019_782736_0008 and Follow Up inspection #2019_782736_0007 were conducted concurrently with this Critical Incident System inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing Services (DONS), the Associate Director of Nursing Services (ADONS), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), housekeepers and residents.

During the course of the inspection, the Inspector(s) also conducted a daily tour of the resident care areas, observed staff to resident interactions and the provisions of care, reviewed training records, and the home's policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **4 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A Critical Incident System (CIS) report was submitted to the Director on a specific date, in relation to resident #002, who fell on the day prior, and sustained a significant injury that required transfer to hospital.

Inspector #736 reviewed resident #002's electronic health records and noted that in the post fall assessment progress notes on two different specific dates, the Registered Staff members indicated that the resident had a specific fall prevention intervention in place. The Inspector was not able to locate any direction in the resident's plan of care related the specific fall prevention intervention.

In an interview with the Inspector, Personal Support Worker (PSW) #107 indicated that resident #002 had a specific fall prevention intervention. The PSW could not recall when the specified intervention had been added to the resident's plan of care.

In an interview with the Inspector, Registered Practical Nurse (RPN) #106 indicated that they were present on the specified day, when resident #002 fell. They recalled that the resident had a specified fall prevention intervention, and could not recall how long it had been in place. RPN #106 indicated that the specific intervention would have been listed in the resident's plan of care. Together, the Inspector and the RPN reviewed the plan of care for resident #002, and could not locate the specific fall intervention. RPN #106 indicated to the Inspector that the specific intervention should have been in the resident's plan of care.

In an interview with the Restorative Care Coordinator (RCC), they indicated to the Inspector that they were responsible to update a resident's plan of care with new interventions related to falls prevention and management, as required. The RCC indicated that resident #002 was at risk for falls, and had had a specified fall prevention intervention added the day prior to the fall. The RCC stated that it had not been added to the resident's plan of care at that time, as the home was waiting to have a different fall prevention intervention initiated. The RCC indicated that without the specified fall prevention intervention being included in resident #002's plan of care, staff would not have been aware that it was a required intervention.

In an interview with the Inspector, the Director of Nursing Services (DONS) indicated that any interventions for a resident in relation to fall prevention and management would be included in a resident's plan of care. Together, the DONS and the Inspector reviewed the plan of care for resident #002 and could not locate the specified fall prevention intervention. The DONS indicated that the written plan of care did not set out the planned care for resident #002. [s. 6. (1) (a)]

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 there is a written plan of care that sets out the planned care for the resident, to be implemented voluntarily.

WN #2: 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 this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any strategy, the strategy was complied with.

In accordance with O.Reg 79/10, s.49 (1), the licensee was required to ensure that the falls prevention and management program, at a minimum, provided for strategies to reduce or mitigate falls, including the monitoring of residents.

Specifically, staff did not comply with the section of the licensee's policy, "Falls Prevention and Management", #VII-G-60.00, last revised August 2017, which was part of the licensee's Falls Prevention and Management Program, that stated the fall risk assessment was to be completed on Point Click Care (PCC) when triggered by the Minimum Data Set (MDS) Resident Assessment Protocol.

Inspector #690 and Inspector #736 reviewed a policy titled "Falls Prevention and Management", policy #VII-G-60.00, last revised August 2017. The policy indicated that a falls risk assessment was to be completed on PCC upon admission of a resident and when triggered by MDS Resident Assessment Protocol.

In an interview with Inspector #690, RPN #116, who was also the Resident Assessment Instrument (RAI) Coordinator for the home, they indicated that the falls risk assessment was to be completed on admission, at a minimum annually, and at any time when a resident's MDS assessment indicated that they had fallen within set parameters.

a) Inspector #690 conducted a review of resident #004's electronic health records and identified a falls risk assessment completed on the day of admission. The Inspector could not locate any other falls risk assessments for resident #004.

A review of resident #004's later MDS assessment indicated that resident #004 had fallen within the set parameters.

In an interview with Inspector #690, RPN #116 indicated that resident #004 should have had a falls risk assessment completed during the MDS quarterly assessment as resident #004 had multiple falls.

In an interview with the DONS, they indicated that a fall risk assessment was to be completed quarterly on every resident when the MDS assessment indicated that the resident had a fall in the set parameters. Together, Inspector #690 and the DONS reviewed the electronic assessments and the MDS assessment for resident #004. The DON indicated that resident #004 did not have a falls risk assessment completed with the quarterly MDS assessment, and that they should have. (690)

b) Inspector #736 conducted a review of resident #002's electronic health records and identified a falls risk assessment completed at an earlier time in the year, as a quarterly assessment. The Inspector could not locate any further falls risk assessments for resident #002.

A review of resident #002's MDS assessment later in the year, indicated that resident #002 had fallen within the set parameters.

In an interview with the DONS, they indicated that a fall risk assessment was to be completed quarterly on every resident when the MDS assessment indicated that the resident had a fall in the set parameters. Together, Inspector #736 and the DONS reviewed the electronic assessments and the MDS assessment for resident #002. The DONS indicated that resident #002 did not have a falls risk assessment completed with the quarterly MDS assessments and that they should have as per the home's policy. [s. 8. (1) (a),s. 8. (1) (b)]

WN #3: 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 had been assessed and if required, a post fall assessment had been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A CI report was submitted to the Director for an incident that caused an injury to a resident that resulted in a transfer to hospital. Please see Written Notice (WN) #1 for details.

Inspector #690 conducted a review of resident #004's electronic progress notes and identified a post fall assessment note on a specified date that indicated that resident #004 had a fall on a date prior to the date the progress note was initiated. The post fall assessment note was saved in a draft form and was not completed in entirety. The sections of the post fall assessment note to indicate cause of fall, description of the fall, any referrals that were required, the fall prevention interventions that were in place at the time of the fall, and any interventions that were put in place to prevent another fall were not completed.

Inspector #690 reviewed a policy titled "Falls Prevention and Management", policy #VII-G-60.00, last revised August 2017. The policy indicated that if a fall occurs, registered staff will complete a thorough investigation including all contributing factors. The policy further indicated that registered staff were to complete a falls incident report and an associated progress note, re-evaluate the care plan, make appropriate referrals and document appropriate interventions to be taken.

In an interview with Inspector #690, RPN #115 indicated that they were working on the date when resident #004 fell and that they were responsible for completing the post fall assessment. RPN #115 indicated that a post fall assessment was to be completed after every fall and was to include information on what caused the fall, any interventions that were in place at the time of the fall and any further interventions that were required to prevent another fall. RPN #115 identified that they did not complete the post fall assessment for resident #115 and that they should have.

In an interview with the DONS, they indicated that a post fall assessment was to be completed after every fall, in entirety and that a post fall assessment was not completed after resident #004's fall. [s. 49. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee has failed to ensure that the quality improvement and utilization review system as required under LTCH Act, 2007, section 84, complied with each record being maintained by the licensee setting out the names of the persons who participated in evaluations, and the dates improvements were implemented.

A) Inspector #736 reviewed the Quality Management-LTC Program/Committee Evaluation Tool for the Fall Prevention Program. The evaluation tool listed the chair of the committee, however did not include the names of the persons who participated in the evaluations. The tool further indicated that the home was going to increase the "implementation of nutrition and hydration" into the fall prevention program, and that the home was going to increase tracking of admissions to the hospital, in relation to falls utilizing the Point Click Care (PCC) hospital transfer tool. The tool did not have any dates that the improvements were implemented.

B) The Inspector reviewed the Medication Management Program for 2018. The evaluation tool listed the chair of the committee, however did not include the names of the persons who participated in the evaluations. The tool further indicated that the home was going to complete the Medication Safety Self Assessment (MSSA), and had addressed any unmets, as well as completed mandatory education as per the Ministry of Health (MOH) order. The tool did not have any dates that the improvements were implemented.

In an interview with the Inspector, the DONS indicated that they did not really keep a record of who had participated in the program evaluations, however they may have kept a record of who attended the Resident Risk and Quality Meeting and those people would have participated in the evaluations. The Inspector was provided with documents related to the Resident Risk and Quality Meeting in February when the program evaluations took place, however there was no attendance list provided and no record of who had participated in the program evaluations, or when improvements had been made. [s. 228. 4. iii.]

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Issued on this 3rd day of May, 2019

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

Original report signed by the inspector.