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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 3, 2016	2016_433625_0007	012627-16	Critical Incident System

Licensee/Titulaire de permis

SIOUX LOOKOUT MENO-YA-WIN HEALTH CENTRE
Fifth Avenue South PO Box 909 SIOUX LOOKOUT ON P8T 1B4

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

William A. 'Bill' George Extended Care Facility
75 FIFTH AVENUE SIOUX LOOKOUT ON P8T 1K9

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

KATHERINE BARCA (625)

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): May 24 to 27, 2016.

A Follow-Up Inspection #2016_433625_0006, related to the home's Continence Care and Bowel Management Program and bed system evaluations, was completed concurrently with this inspection.

A log related to a critical incident the home submitted, regarding a fall resulting in a transfer to hospital, was also completed during this inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Team Leader, a Registered Practical Nurse (RPN), Personal Support Workers (PSWs), an Activity Worker and residents.

The Inspector also reviewed resident health care records, various home's policies and procedures. The Inspector completed observations of residents, observed the provision of care and services to residents, observed resident and staff interactions and conducted a tour of resident care areas.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition

During the course of this inspection, Non-Compliances were issued.

- **2 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. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the 24-hour admission care plan identified any risks that the resident may have posed to himself or herself, including any risk of falling, and interventions to mitigate those risks.

A review by Inspector #625 of resident #011's "Hospital Minimum Data Set Home Care" (MDS-HC) completed in the winter of 2015, which was provided to the home with the resident's admission application, identified that the resident required the assistance with transferring, used an assistive device for locomotion, had fallen a specific number of times in the 90 days preceding the assessment, had been admitted to hospital due to falls and had sustained an injury related to a fall.

A review of resident #011's "Personal Health Profile" completed in the winter of 2015, which was provided to the home with the resident's admission application, identified that, under the heading of physical functioning, the resident required the use of an assistive device and had a potential problem related to falls.

A review of resident #011's "24 Hour Plan of Care Form" completed by the home on a specific day in the winter of 2016, identified that the resident had experienced a previous injury, had a sensory impairment requiring an sensory aid which they were not wearing and could not locate at the time of admission to the home, and required no assistance with locomotion and transfers. The form did not indicate that the resident had a potential problem related to falls or used an assistive device for locomotion.

A review of the resident's progress notes identified that the resident was admitted to the home on a specific date in the winter of 2016, in the early afternoon. During the early evening of the same day, the resident had tripped, fell to the floor and was unable to stand. The resident was transported to the Emergency Department and returned to the home later that evening with an injury.

During an interview with Inspector #625 on May 26, 2016, the DOC acknowledged that the resident's "24 Hour Plan of Care Form" dated the winter of 2016, completed by the home, identified that the resident had no potential physical functioning problems related to falls. The DOC stated that the form did not reflect the resident's risk of falling. [s. 24. (2) 1.]

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, the 24-hour admission care plan identifies the resident and includes, at a minimum, any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks, to be implemented voluntarily.

WN #2: 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 had fallen, the resident had been assessed and, if required, a post-fall assessment had been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A Critical Incident System (CIS) report was submitted to the Director regarding a fall which occurred on a specific date during the winter of 2016, where resident #011 was taken to hospital and which resulted in a significant change in the resident's health status.

The home's policy in place at the time of the resident's fall, “Fall Prevention – LTC.2.90” last revised April 5, 2012, identified that every resident would be assessed for risk for fall and injury using the “Fall Risk Assessment”. The policy indicated that the “Fall Risk Assessment” would be reassessed with any falls.

A review of resident #011's progress notes identified that the resident fell on a specific date in the winter of 2016, which resulted in an injury to the resident.

A review of resident #011's health care record by Inspector #625 did not identify a “Falls Risk Assessment” completed for resident #011 on the specific date of the resident's fall in the winter of 2016.

During interviews with Inspector #625, the Team Leader and the DOC both stated that they could not locate a "Falls Risk Assessment" completed for resident #011 after the fall that occurred on the specific date in the winter of 2016. [s. 49. (2)]

Issued on this 4th day of November, 2016

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

Original report signed by the inspector.