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
Jul 11, 2019	2019_624196_0019	013358-18, 023510-18	Critical Incident System

Licensee/Titulaire de permis

Sioux Lookout Meno-Ya-Win Health Centre
1 Meno-Ya-Win Way P.O. Box909 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

LAUREN TENHUNEN (196)

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): July 2 - 4, 2019.

The following intakes were inspected during this Critical Incident System (CIS) inspection:

- Two intakes related to residents' falls that resulted in a significant change to their health condition.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, the Resident Assessment Instrument (RAI) coordinator, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The Inspector also observed the provision of care and services to residents, observed staff to resident, and resident to resident interactions, reviewed relevant health care records, home's internal incident reports, staff schedules, Critical Incident System (CIS) reports, and the home's falls prevention and management program and policies.

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

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	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. 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 resident #001 fell on an identified date, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A Critical Incident System (CIS) report was submitted to the Director for a fall that occurred on an identified date for which resident #001 was taken to hospital and which resulted in a significant change in the resident’s health status.

During a review of resident #001’s health care record, Inspector #196 was not able to locate a post fall assessment completed for the fall that had occurred on the identified date. The hand-written progress notes documented by RPN # 101, identified the circumstances of the resident’s fall, an assessment of the resident and the injury, and actions taken. The home’s internal incident report identified the circumstances surrounding the fall and that the resident had sustained an injury to an area of their body which required treatment.

During an interview with RPN #101, they reported that at the time of resident #001’s fall, there wasn’t a post fall assessment tool to use.

During an interview with RAI coordinator #102 and the Administrator/Director of Care, regarding the resident’s fall, they reported that the post fall assessment was documented in a hand-written progress note. They further confirmed that the home did not have a clinical assessment tool specifically designed for falls. [s. 49. (2)]

2. The licensee has failed to ensure that, when resident #002 fell on an identified date, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A CIS report was submitted to the Director for a fall that occurred on an identified date, for which resident #002 was taken to hospital and which resulted in a significant change in the resident’s health status.

During a review of resident #002’s health care record, Inspector #196 was not able to locate a post fall assessment completed for the fall that had occurred on the identified

date. The progress notes in Mede Care, documented by RPN # 101, identified the circumstances of the resident's fall, an assessment of the resident's injury, and actions taken. The home's internal incident report identified the circumstances surrounding the fall and that the resident had sustained an injury to an area of their body.

During an interview with RAI coordinator #102 and the Administrator/Director of Care, regarding the resident's fall, they reported that the post fall assessment was documented in a hand-written progress note. They further confirmed that the home did not have a clinical assessment tool specifically designed for falls at the time of this resident's fall. [s. 49. (2)]

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 that ensures 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, to be implemented voluntarily.

WN #2: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that, when required to inform the Director of an incident under subsection (3.1), including resident #001's fall on an identified date, that, within 10 days of becoming aware of the incident, or sooner if required by the Director, a report was made in writing to the Director setting out the outcome or current status of resident #001 with respect to their fall.

A CIS report was submitted to the Director for a fall that occurred on an identified date for which resident #001 was taken to hospital and which resulted in a significant change in the resident's health status. The report was submitted and identified the circumstances of the resident's fall, the notifications of the required persons, and the transfer to the acute care hospital.

The Inspector reviewed the CIS report and could not locate an update to the submitted report with the resident outcome or current status with respect to the fall that had occurred on the identified date.

The health care record for resident #001 was reviewed. The internal incident report identified the resident had sustained an injury to an area of their body and was sent to the acute care hospital for treatment and then had treatment at another acute care hospital.

During an interview with RPN #101, they provided updated information to the Inspector regarding resident #001.

During an interview with the Administrator/Director of Care, they confirmed that there had not been any updates to the submitted CIS report with the outcome or current status of the resident after the fall. [s. 107. (4) 3. v.]

Issued on this 11th day of July, 2019

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

Original report signed by the inspector.