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
Oct 25, 2019	2019_680687_0028	016279-19	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

LOVIRIZA CALUZA (687)

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): October 15 to 18, 2019.

The following intake was inspected during the Critical Incident System (CIS) Inspection:

- One intake related to a resident's fall that resulted in an injury.

During the course of the inspection, the inspector(s) spoke with the Administrator/Acting Director of Care (Acting DOC), the Team Lead, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant health care records, as well as relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

The home submitted a CI report to the Director, which indicated that resident #001 had a fall and sustained an injury.

During an observation, Inspector #687 observed resident #001 in a specific location with a specified transfer intervention.

Inspector #687 reviewed resident's #001 electronic progress notes on a specified date, it indicated that resident #001 sustained a fall and was sent for further assessment due to a potential injury. A subsequent review of the electronic progress notes, indicated that resident #001 had returned to the home post management of their injury.

In a review of the resident's electronic progress note completed by Physiotherapist (PT) #105 on a specified date, the PT recommended and advised that resident #001 was to continue to use a specified transfer intervention.

In a review of resident #001's electronic care plan in effect at that time of the inspection, under the focus "Falls", it indicated that resident #001 was to be transferred with a specified transfer intervention.

Inspector #687 reviewed the home's policy titled, "Fall Prevention and Management Program in Long Term Care" approved date on January 25, 2019, which indicated "To monitor and evaluate the care plan at least quarterly in collaboration with the interdisciplinary team". The policy also indicated that "If the interventions were not effective in reducing falls, initiate alternate approaches and update the care plan".

During an interview with PSW #107, they stated that prior to resident #001's fall incident, the resident was transferred with a specified transfer intervention. When the resident returned to the home post injury, the staff were made aware that the resident was to be transferred with a specific transfer intervention.

In an interview with the Team Lead, they stated that they were responsible for updating resident #001's care plan. The Team Lead further stated that they were aware of the PT assessment regarding resident #001's transfer and they had updated the care plan. However, because the resident's care plan review date was not changed, it did not saved the revision in the resident's care plan . [s. 6. (1) (c)]

2. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

a) The home submitted a Critical Incident (CI) report to the Director, which indicated that resident #001 had a fall and sustained an injury.

In an observation conducted by Inspector #687, resident #001 had a specified intervention attached to a specified location.

During a review of resident #001's electronic care plan, under the focus "Aids to Daily Living", it indicated that the staff were to ensure that they performed a specific action for the specified intervention when resident #001 was in bed.

In a review of resident #001's electronic POC documentation record and progress notes, Inspector #687 did not identify any documentation record pertaining to the specific action of resident #001's specified intervention.

During an interview with Personal Support Worker (PSW) #101, they stated that resident #001 had a specified intervention and that the staff were to perform a specific action when the resident was in bed. The PSW further stated that they were to document this specific action in their electronic POC tasks.

Inspector #687 conducted an interview with Registered Practical Nurse (RPN) #103, they stated that resident #001 had a specified intervention and that the staff performed a specific action when the resident was in bed. The RPN further stated that there was no documentation record pertaining to the specified action of resident #001's specified intervention since the resident's admission until a specified date.

In an interview with the Administrator/Acting Director of Care (DOC), they stated that resident #001 had a specified intervention. The Administrator/Acting DOC further stated that there was no record of the specified intervention for resident #001 and that they had recently initiated this specific action. The Administrator/Acting DOC stated that it was their expectation that staff would ensure that when resident #001 was assisted back to their bed, the staff would check the specified intervention and specific action and document it in the resident's electronic POC task.

b) In an observation conducted by Inspector #687, resident #003 had a specified intervention attached to a specific location.

During a review of resident #003's electronic care plan, under the foci "Bed Mobility and Aids to Daily Living", it indicated that the staff were to ensure that they performed a specific action for the specified intervention when resident #003 was in bed.

In a review of resident #003's electronic Point of Care (POC) documentation record and progress notes on specified dates, Inspector #687 did not identify any documentation record pertaining to the specific action of resident #003's specified intervention.

During an interview with the Team Lead, they stated that resident #003 had a specified intervention and that the staff were to perform a specific action when the resident was assisted to bed. The Team Lead further stated that there was no documentation record pertaining to the specific action for resident #003's specified intervention on the specified dates.

c) In an observation conducted by Inspector #687, resident #004 had a specified intervention attached to a specified location.

A review of resident #004's electronic care plan on a specified date, under the focus "Falls", it indicated that the specified intervention required a specific action when resident #004 was in bed.

In a review of the resident #004's electronic POC and progress notes from specified dates, Inspector #687 did not identify any documentation record pertaining to the specific action of resident #004's specified intervention.

During an interview with the Team Lead, they stated that resident #004 had a specified intervention and that the staff were to perform a specific action when the resident was in bed. The RPN further stated that there was no documentation record pertaining to the specific action for resident #004's specified intervention since the resident's admission date until a specified date. [s. 6. (9)]

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 provision of care set out in the plan of care is documented as well as to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident, 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 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.

The home submitted a Critical Incident (CI) report to the Director, which indicated that resident #001 had a fall and sustained an injury

Inspector #687 reviewed resident's #001 electronic progress notes on specified dates, it indicated that resident #001 had an unwitnessed fall documented by RPN #108, #109 and #104.

In a review of resident #001's specified assessment, Inspector #687 was unable to identify the specified assessments initiated by registered staff on the specified dates.

A review of the home's policy titled "Fall Prevention and Management Program in Long Term Care" approved date on January 25, 2019, it indicated that registered staff were to initiate a specific assessment for all witnessed and unwitnessed falls that resulted in an injury or if the resident was prescribed with a specific therapy.

During an interview with RPN #104, they stated that if a resident had an unwitnessed fall incident, the RPN was to initiate the specified assessment unless contraindicated as ordered by the physician.

In an interview conducted by Inspector #687 with the Team Lead, they stated that resident #001 had an unwitnessed fall incidents on specified dates and that there were no specified assessments initiated at that time. [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 to ensure that when a resident had fallen, the resident is assessed and that where the condition or circumstances of the resident required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #3: 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 the following incidents in the home no later than one business day after the occurrence that caused an injury to a resident for which the resident was taken to a hospital and resulted in a significant change in the resident's health condition.

The home submitted a CI report to the Director, which indicated that resident #001 had a fall and sustained an injury.

In a review of the CI report submitted by the home to the Director regarding resident #001's fall incident which resulted in an injury, Inspector #687 identified that the CI report was initiated on a specified date.

Inspector #687 reviewed resident's #001 electronic progress note on a certain date, and identified that resident #001 had a fall and that they were sent for further assessment due to a potential injury. A subsequent electronic progress notes, indicated that resident #001 had returned to the home post management of their injury.

A review of the home's policy titled "Reporting Critical Incidents in Long-Term Care" effective date August 2006, it indicated that "An injury in respect of which a person was taken to hospital, the Director should have been informed of the incident within one business day of becoming aware of the incident and the full report within 10 business days".

In an interview conducted by Inspector #687 with the Administrator/Acting DOC on a specified date, they stated that it was their mistake that it was not reported. [s. 107. (3) 4.]

Issued on this 1st day of November, 2019

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

Original report signed by the inspector.